The President's Comprehensive Health Reform Program

February 6, 1992

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Chapter 1

Overview

HIGHLIGHTS: The President's Plan For Comprehensive Health Care Reform

The President's Plan is a **comprehensive, market-based** reform that builds on the strengths of our current system to provide access to *affordable insurance* for all Americans.

- **The President's plan guarantees access to health insurance for *all* poor families** through a transferable health insurance tax credit (certificate)—available even to those too poor to file taxes—that is large enough to purchase a basic health package ($3,750 for a family).
- **The President's plan provides insurance security for all Americans.** The fear of "job lock"—where workers can't move to another job without losing access to insurance—is eliminated. Limits on the availability of insurance for those with "preexisting conditions" are eliminated.
- **The President's plan will *reduce the cost* of health insurance through major market reforms.** Smaller businesses and individuals would be pooled into larger groups—so they can receive the same favorable health coverage enjoyed by large employers. Millions of people who now can not find affordable insurance will be helped.
- **The President's plan provides new help to the middle class to pay for health care.** Up to $3,750 in health insurance costs can be deducted by families with incomes less than $80,000. Over 90 million Americans will receive new assistance for health costs.
- **The President's plan encourages the growth of coordinated care**—in private plans, Medicare and Medicaid. Laws limiting coordinated care would be prohibited—as would costly State mandated benefit laws. The comprehensive plan encourages individuals, employers and health providers to use coordinated care systems.
- **The President's plan will use the power of an informed marketplace to help control costs** by providing consumers with better information and by giving individuals the resources to choose the coverage that best meets their needs.
- **The President's plan would reduce administrative costs** through regulatory reforms that will streamline the current paperwork maze, and through market reforms that allow small employers to share—and thereby substantially reduce—administrative costs.
- **The President's plan includes major malpractice reform.** A comprehensive liability reform plan is proposed to reduce the costs of malpractice and the resulting defensive medicine that burdens the U.S. health system.
- **The President's plan would expand services in underserved areas.** Many inner city and rural areas have acute shortages of doctors and clinics. The President's budget expands funding for Community Health Centers, Migrant Health Centers and the National Health Service Corps to increase preventive care in these areas.

The President's Plan Does Not:

— include governmental price regulation or rationing of health care;
— burden small business with new and costly mandates that will stifle the creation of new jobs and be passed on in higher product costs and higher taxes for all Americans;
— require massive tax increases like "play or pay" and national health insurance;
— threaten poor older Americans with benefit reductions or premium increases.

The President's Plan builds on a system that provides the world's best health care. The plan provides all Americans access to affordable health care coverage through a transferrable health insurance credit (certificate)—available even to low-income Americans who do not file tax returns—that can be applied to the purchase of a basic health benefit package. To reduce the rapid growth of health spending, the plan makes radical reforms in the health insurance system and includes strong incentives for the development and expansion of coordinated care systems and other efficient arrangements for delivering high quality health care.

Summary Highlights

Expanding Access to Health Care (See Chapters 3 and 4)

Transferrable Health Insurance Credits (certificate) and Deductions—Benefitting Approximately 95 Million Americans—

- A transferrable health insurance credit (certificate) or tax deduction would be available to ensure access to affordable health care coverage for moderate and low-income families. About 95 million Americans would receive assistance. When fully implemented, families with incomes below the tax filing threshold, approximately the poverty line, would receive a credit of up to $3,750, sufficient to purchase basic health benefits. Similarly, individuals would receive $1,250 and two-person families $2,500. A health insurance credit (certificate) or deduction (also up to $3,750 per family) would be available to individuals, two-person, and larger families with annual incomes up to $50,000, $65,000 and $80,000, respectively.

Market Reform—

- *Basic Benefits.*—States would be required to develop a basic health insurance package equal to the value of the health insurance credit. This would enable low-income families to purchase adequate health care coverage.
- *Insurance Security.*—Workers changing jobs would no longer face concerns about "job lock"—the inability to change jobs for fear of losing access to insurance. Health insurers would be required to provide coverage to all employers requesting it. Coverage would be guaranteed, renewable, and preexisting condition limits would be eliminated.
- *Health Insurance Networks (HINs)—Pooled-Purchasing Power.*—When it comes to health insurance, small businesses do not have many of the advantages of large businesses. Large companies can self insure and avoid expensive benefit mandates and premium taxes. Large firms are sold coverage similar to that purchased by small firms, but at much lower prices. A new way of purchasing insurance, HINs would enable small firms to purchase low cost, high quality health insurance. HINs would enable small businesses to buy lower priced insurance by reducing administrative costs and by exempting insurance purchased from HINs from excessive State mandates, anti-managed care laws, and premium taxes. For the first time, groups like the National Federation of Independent Business, National Small Business United, and the U.S. Chamber of Commerce would be able to offer affordable health plans to their members nationwide or join with other groups to increase purchasing power in State or local markets.
- *Insurance Affordability.*—In the near term, premium costs for similar policies sold to firms in a single block of business could vary by no more than 50 percent. A health risk adjustment across insurers would be phased in—removing premium disparities and allowing for plan flexibility within a new insurance market driven by competition on quality and costs.

Containing Health Care Costs (See Chapter 5)

- *Malpractice Reform.*—The threat of malpractice litigation prompts physicians to order tests and perform procedures, enabling them to assert that every effort has

been made to provide the best health care. These defensive practices are extremely costly to the system. To address this, the President's plan would provide incentives to States to: (i) eliminate joint and several liability for non-economic damages, (ii) cap non-economic damages, (iii) eliminate rules that permit double recovery, (iv) require structured awards, (v) promote pretrial alternatives, and (vi) implement new procedures to improve quality of care. Also, standards of care, developed in conjunction with the medical community, would be explored as a means to remove physician uncertainty over malpractice litigation.

- *Improving Consumer Information.*—To assist individuals and employers in evaluating various health insurance policies, consumers would have access to information, that would provide information like that in "blue books" on the average cost of services and the quality of care provided by physicians, hospitals, clinical laboratories, and other health care providers. This will help control costs by providing consumers with comparative value information that will enable them to make more informed choices.

- *Reducing Administrative Costs.*—The President's plan will reduce administrative costs, which now total $43 billion a year, by more than 25 percent through electronic billing for providers, electronic benefit cards for policyholders, simplified utilization review, and insurance market reforms.

  Insurance law changes and market reforms will cut back the paperwork blizzard that confronts all insured Americans—and costs billions of dollars. Standardized claims procedures and other reforms will reduce administrative costs. For small employers, administrative costs may account for as much as 40 percent of the cost of insurance purchased. Marketing to and servicing small employer policies is costly. HINs, which unite many purchasers, would reduce the cost of insurance administration and premiums. These costs are usually under 10 percent for large businesses. Federally certified HINs would also be required to adhere to uniform claims processing procedures, a source of additional administrative savings.

- *Expanded Use of Coordinated Care*—

  —In 1990, approximately 40 million Americans were enrolled in a coordinated care system—up from 10 million in 1980. The President's plan encourages broader use coordinated care including preferred provider organizations, point-of-service choice plans, case management, HMOs, and other forms of coordinated care.

  —States would be encouraged to develop coordinated care systems and would be prohibited from having laws that hinder effective operation of these systems. Excessive State-mandated benefits—that increase the cost of insurance—would be prohibited.

  —Medicare reforms would encourage increased coordinated care enrollment and increase incentives for coordinated care systems to contract with Medicare. The President's plan also would make it easier for beneficiaries of retiree group health benefit plans to be served by coordinated care systems.

- *Increased Flexibility for State Programs.*—States are encouraged to implement a coordinated care-based Medicaid program. They also would have the flexibility to redesign their entire health care systems.

  —States could choose to combine current Medicaid funding with the new benefits provided through the health insurance credit (certificate) to develop a single unified health plan for their low-income residents.

  —With the new Federal health insurance credit (certificate), all poor residents are guaranteed basic health coverage—without any further fiscal burden on the States. This will allow States to more effectively allocate their health resources for Medicaid and for the nonpoor population.

- *Cost-Effective Services are Expanded in Underserved Areas.*—The inner city and rural areas have acute shortages of doctors and clinics. The President's fiscal year 1993 Budget expands funding for Commu-

nity Health Centers, Migrant Health Centers, and the National Health Service Corps to expand preventive care in these areas.

- *Prevention.*—The President's fiscal year 1993 Budget includes $26.4 billion, an increase of nearly $4 billion (18 percent), for preventive health activities. Prevention funding has increased by more than $11 billion (74 percent) since 1989. The President's fiscal year 1993 Budget proposes increases of 18 percent for childhood immunizations and infant mortality reduction, a 27 percent increase for Head Start and Early Childhood Development, a 24 percent increase for breast and cervical cancer mortality prevention, and a 90 percent increase for childhood lead poisoning prevention.

Alternative Approaches (See Chapter 6)

The two alternative approaches to health care reform have fundamental structural weaknesses:

- *Canadian Model.*—In Canada neither providers nor consumers have incentives for efficiency; health care costs are growing faster than in the U.S.; patients endure long lines and wait for surgery and access to advanced technology; and, high quality care is rationed. A Canadian-style plan would require from $250 billion to $500 billion a year in new taxes. For quality care, many Canadians go to the U.S.
- *Play-or-Pay Model.*—"Play-or-pay" would hurt workers by increasing unemployment and forcing employers to cut wages to offset mandated costs. One study indicates that under "play-or-pay" between 400,000 to 700,000 jobs would be lost in the short-run, and up to 2 million jobs could be lost in the long-run. The "play-or-pay" system is structurally unsound and guaranteed to degenerate into national health insurance. Upon enactment, 59 million privately-insured Americans would fall into the public plan and the plan's instability would quickly force universal public coverage. Play-or-pay is a tax on low-wage workers and would result in millions of lost jobs. Finally, at least $37 billion per year in new and additional taxpayer-financed subsidies would be required to adequately fund the public plan.

Chapter 2

Principles for Reform: Building on American Strengths

Overview

- The cost growth of the U.S. health care system is unsustainable, both for individual Americans and for the economy as a whole.
- Even with rapidly increasing health spending, 13 percent of Americans do not have access to health insurance.
- Most federal health care support goes to the non-poor, the segment of society that least needs government assistance.
- Despite the shortcomings of the American system, it delivers the world's best quality care, and the world's most sophisticated health technology.
- Reform should preserve the strengths of the U.S. system while addressing its weaknesses. Reforms should not destroy its incentives for choice, quality, and innovation.
- The President's Principles for Reform establish guidelines for a comprehensive restructuring of a market-based health system.

Americans need and deserve adequate access to affordable high quality medical care. Health care in the United States has evolved into the world's most sophisticated and advanced system.

Our health care system has strengths and weaknesses. A clear understanding of both is essential in guiding policy development.

Principles for Reform

The President has determined that several principles should guide the development of a comprehensive approach to health reform. The reform *should:*

- Build on the strengths of an American health system that provides the highest quality health care in the world;
- Assure access to basic health insurance for Americans, and increase the affordability of such coverage;
- Promote consumer choice to ensure that the health care system continues to respond to the needs and concerns of Americans;
- Strengthen market incentives for providers and health plans to improve quality while controlling costs;
- Emphasize prevention and personal responsibility;
- Reduce abuse and wasteful excess;
- Meet the requirements of fiscal responsibility and budget discipline.

The approach *should not:*

- Force the American people to give up the choice and diversity that makes the American health system unique;
- Lead to comprehensive governmental price controls and rationing health care by government;
- Create new spending mandates for States and employers;
- Require a net increase in taxes; or
- Threaten older Americans with the prospect of either benefit cuts or premium increases.

These tests cannot be met by either "Canadian-style" or "Play-or-Pay" approaches to reform. Such approaches necessarily involve major tax increases, comprehensive governmental price controls, or rationing.

Understanding the Cost and Access Problems

Health care costs are increasing too fast and too many Americans have inadequate access to health care. The causes of the cost and access problems are complex. Unfortunately, simplistic proposals, such as reducing administrative costs to fund a universal access program, are unrealistic (Doherty, 1991).

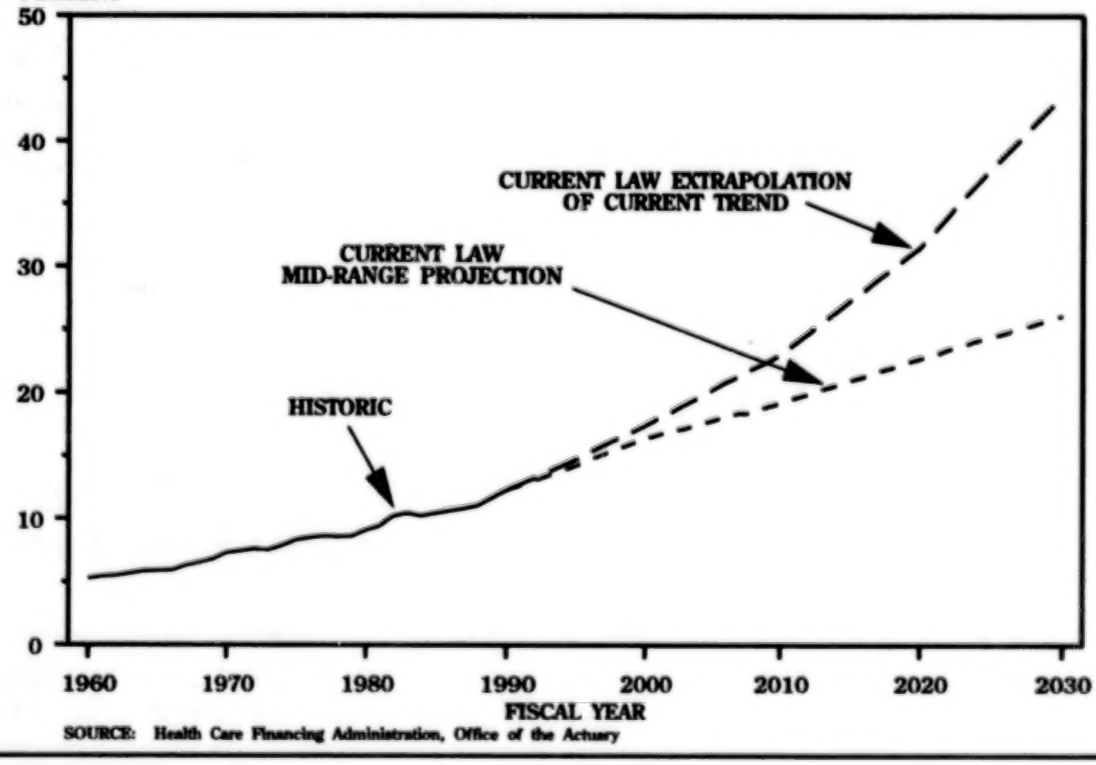
Moreover, the cost and access problems are not easily solved simultaneously. The political system tends to trade cost-control for access, and vice-versa. Addressing the access problem inescapably means re-allocating tens of billions of dollars each year. Addressing the cost problem requires correcting perverse incentives and market distortions—to encourage more efficient behavior by individuals, insurers, and health providers.

Unsustainable Cost Growth.—Currently, total health care expenditures are about 13 percent of the Gross Domestic Product (GDP)—up from less than 6 percent of GDP only three decades ago. If the current system continues unchanged, health care could consume over 16 percent of GDP by the year 2000, and between 27 and 43 percent of GDP by 2030 under mid-range and high-range projections (Sonnefeld et al., 1991).

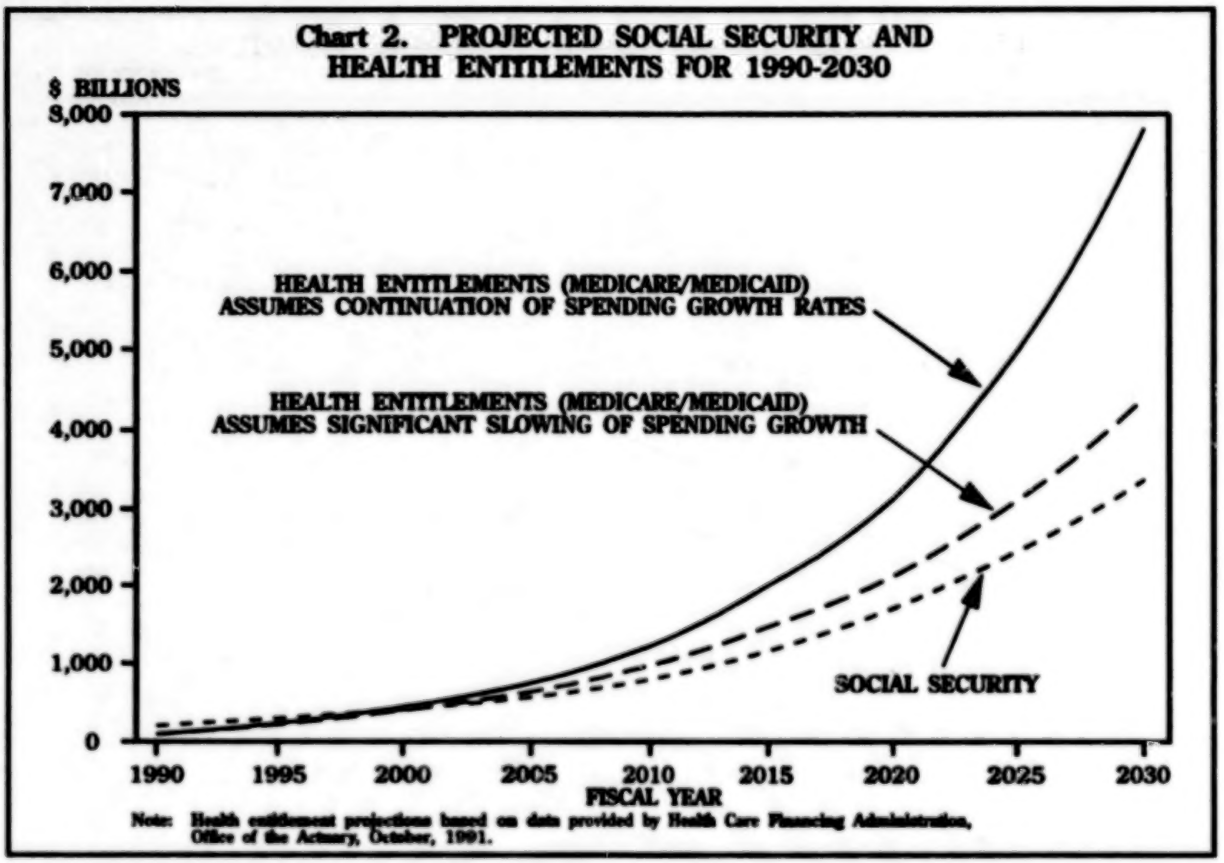
These costs are shouldered by everyone—individuals, business and government. The federal government is spending increasing proportions of the federal budget on mandatory health outlays. Before the year 2000, health entitlement programs (Medicare and Medicaid) will surpass Social Security as the single largest component of federal spending. Federal Medicaid spending alone has grown from $14 billion in 1980 to $37 billion in 1989 to a projected $84 billion in 1993. These figures reflect a 43 percent increase for last year alone, an increase of 227 percent since 1989, and an increase of 600 percent since 1980.

Medicare spending will have grown from $34 billion in 1980 to about $131 billion by 1993—an increase of nearly 300 percent. Unrestrained, Medicare will grow at an average rate of 12 percent per year from 1993

Chart 1. HEALTH SPENDING IS PROJECTED TO REACH 16.4% OF GDP BY 2000 -- RISING FROM 5.3% IN 1960



SOURCE: Health Care Financing Administration, Office of the Actuary



through 1997. By 2025, Medicare is expected to exceed 27 percent of the federal budget.

Even if it were possible to sustain health spending at nearly 30 cents of every dollar, it is difficult to imagine who would pay these enormous costs. Most individuals already feel that they are overburdened with health care costs. Businesses are spending increasing percentages of wages and other compensation on health care premiums—currently in excess of 100 percent of after-tax profits.

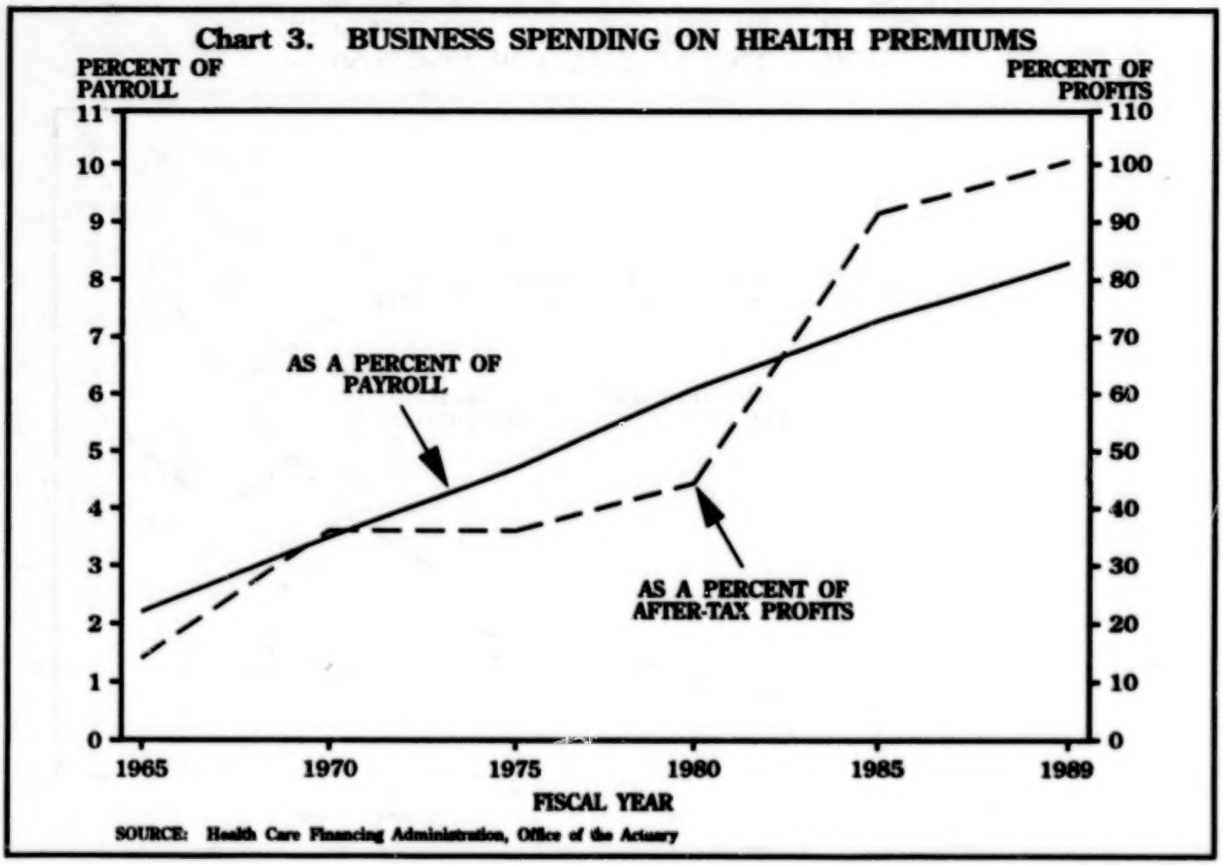
Clearly, health care costs must be contained, both in public programs and in the private sector. Neither individuals, business, nor government can afford to pay for the currently projected growth.

Inadequate Access Despite Increasing Spending.—Despite this rapid rise in health care spending, 13 percent of Americans—34.7 million—are without health care insurance.

Most of the uninsured are lower-income Americans—30 percent of the uninsured have incomes below the poverty level, and 32 percent have incomes between 100 and 200 percent of poverty (Needleman et al., 1990). Despite this, most of the massive federal spending on health care goes to the non-poor. In 1992, only 21 percent of total federal health care spending is estimated to be spent for the poor. Almost 90 percent of Medicare spending goes to individuals above the poverty level.

Uninsured Americans receive some health care, either by paying for it out-of-pocket, or in the form of "uncompensated" or "charity" care (Needleman et al., 1990). "Uncompensated" care is not free, in the sense that insured individuals must pay higher fees and thus higher premiums, and hospitals receive public (such as Medicare and Medicaid "disproportionate share" payments and non-profit tax treatment—now over $15 billion per year) and private (such as charitable contributions) subsidies to cover the costs.

The uninsured are more likely to receive health care in hospital emergency rooms, rather than in physicians' offices and clinics (NMES, 1987). This form of care can be harmful to the individual, who may only



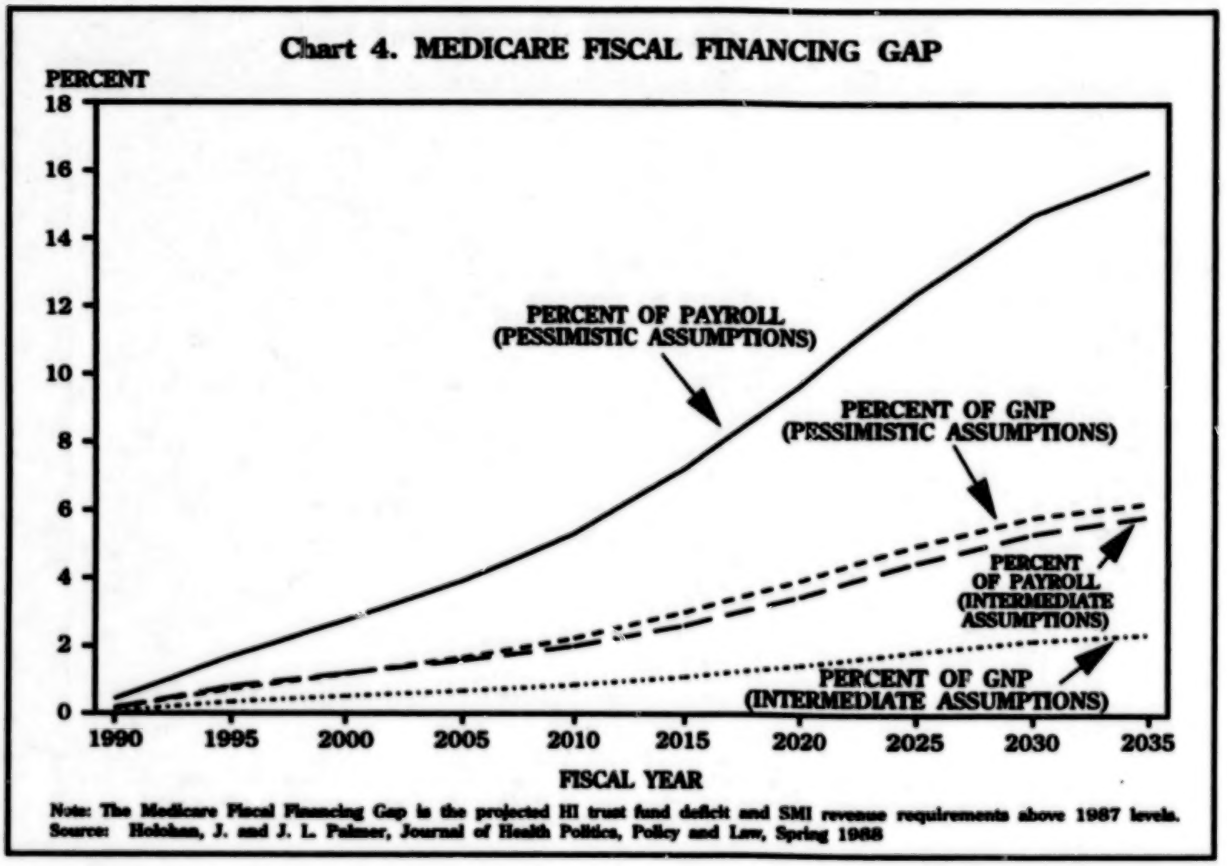
receive care for serious illnesses instead of coordinated, preventive care from a physician familiar with the patient. Emergency room care is also a more expensive and inefficient use of resources, since emergency room visits are much more costly than physician office visits.

No Easy Solution.—Rising health care expenditures are a function of many interrelated factors. These include: general inflation, population growth, relative aging of the population, growth in volume and intensity of medical care (HCFA, 1989), and "cost shifts" that re-allocate the costs of caring for the uninsured. The resulting medical inflation is consistently more than double the growth rate of the Consumer Price Index.

General inflation, population growth and relative aging necessarily occur. Other factors can be addressed, such as the growth in the intensity of medical services and of preventable illnesses. Despite increasing per capita U.S. costs, utilization as measured by hospital admissions, length of hospital stay, and medical visits per capita have been level or increased only slightly. This suggests that the intensity (e.g., more tests and procedures per hospital stay or per office visit) is the primary cause of spending growth. International comparisons confirm this conclusion (Schieber et al., 1991).

In addressing the growth in service intensity, it is difficult to know how much of the increase is due to advances in medical technology, and how much is attributable to excessive defensive medicine, poor health care management, and gaming of a public price-regulated system.

For preventable illnesses and conditions, though, the issues are more apparent. For example, at 13.8 per 100,000, the male homicide rate is more than 12 times that of Germany and 5 times that of Canada. More than 200,000 AIDS cases have been reported in the US. In 1989, the rate of incidence of AIDS was more than three times that of Canada and six times that of then-West Germany. And, there are about 375,000 drug-exposed babies in this country. This problem



is negligible in most other countries (Schwartz, 1991).

Rising costs are also the result of market distortions. Because medical treatment is largely in the hands of doctors and hospitals (who have financial and defensive incentives to provide more medical care) and not the consumer, consumer-based market discipline has been weak.

Under the current system, Americans with insurance are often overinsured and have few incentives to use medical care prudently. Instead, consumers tend to be risk-averse where health is concerned. Insulated from the real cost of medical treatment by employer and government subsidized insurance, Americans tend to over-consume health care. Moreover, because insurance itself is so highly subsidized for most Americans, they have little reason to prefer forms of coverage that are more efficient (e.g., coverage with higher cost sharing or coordinated care coverage)

The health care market is further distorted by limited consumer information about the treatments patients receive and the efficiency of their care. Consumers and large purchasers currently have few objective sources of information on which to base cost and quality comparisons.

The problems of access and cost are inextricably linked. Access ultimately is an issue of affordability. Many low-income Americans need help to be able to afford coverage. Cost growth needs to be slowed to assure continued affordability for others. Thus, the access and cost problems must be addressed together in a comprehensive series of reforms. Only then can all Americans begin to enjoy efficient health care at affordable prices.

Building on American Strengths

Most Americans today have ready access to state-of-the-art medical care. Breakthrough treatments spread rapidly from our Nation's finest hospitals and laboratories and quickly become routinely available throughout the

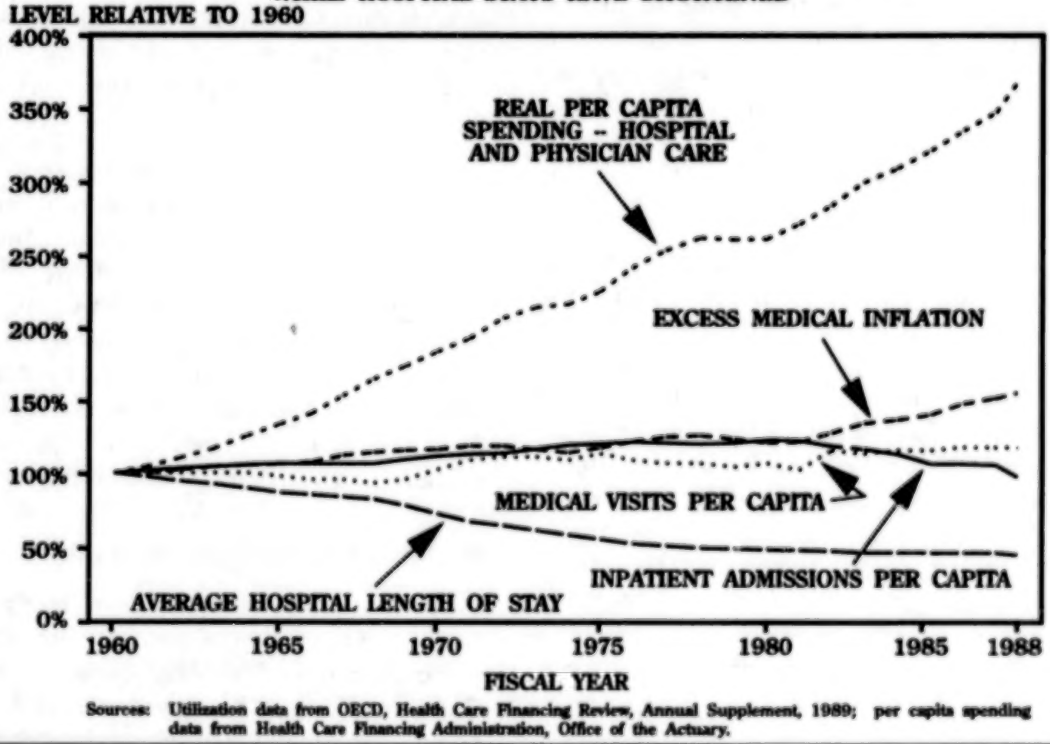
Chart 5. FEDERAL HEALTH SPENDING

NOTE: Federal spending for Medicare, Medicaid, hospital and medical care for veterans, and other payments to individuals for health purposes; and tax expenditures for employment-provided health plans and for deductions of health expenses. Spending share to poor reflects percent of recipients with money incomes below poverty thresholds.

SOURCE: Census Bureau

Chart 6. MOST OF THE GROWTH IN REAL PER CAPITA SPENDING IS DUE TO SERVICE INTENSITY--MORE TESTS AND SERVICES ARE BEING PROVIDED PER ENCOUNTER

HOSPITAL ADMISSION AND PHYSICIAN VISIT RATES HAVE CHANGED LITTLE WHILE HOSPITAL STAYS HAVE SHORTENED



Sources: Utilization data from OECD, Health Care Financing Review, Annual Supplement, 1989; per capita spending data from Health Care Financing Administration, Office of the Actuary.

country. We must preserve this excellence in our efforts to solve our problems.

Vast improvements in health over the last few decades are unmistakable. Charts 7 and 8, for example, show dramatic improvements over the past 40 years in life expectancy and in mortality rates. Overall mortality rates have decreased from 840.5 deaths per 100,000 in 1950 to 535.5 per 100,000 in 1988. Mortality rates for heart disease and for cerebrovascular disease have declined by 46 percent and 66 percent respectively during this period.

Advances in medical treatment are so frequently reported that they seem almost routine. Today, Americans from all walks of life have ready access to these medical advances. (See Chart 12.)

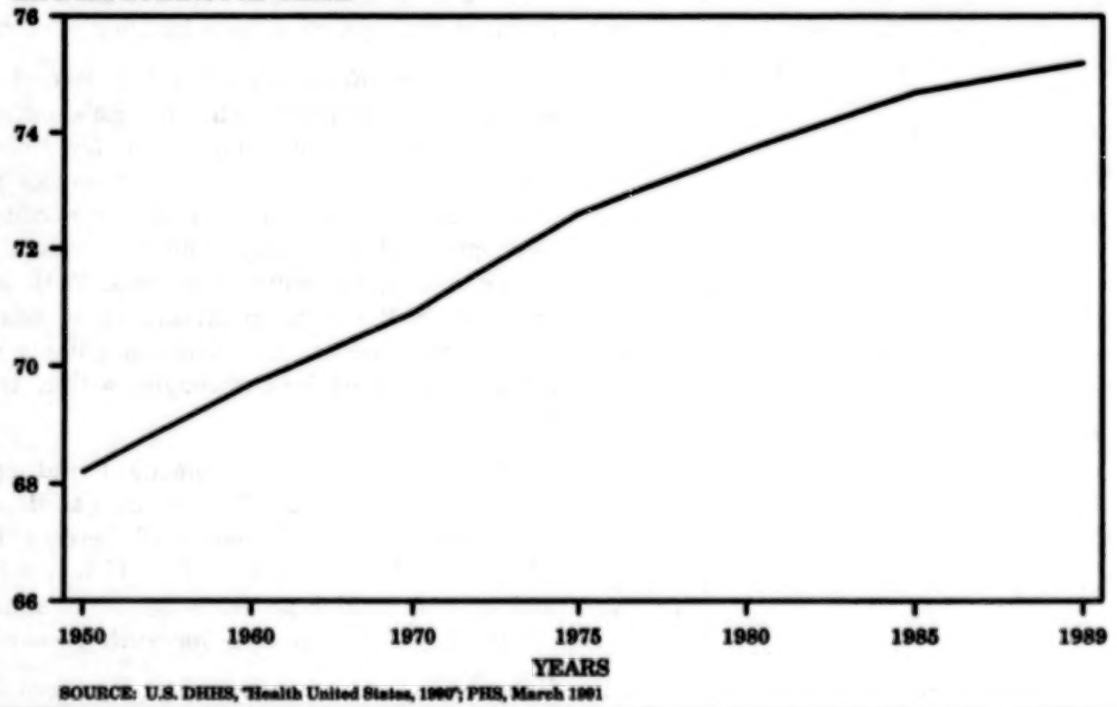
These trends neither reverse nor even plateau. Prevention and greater personal responsibility could increase average life expectancy from about 73.8 years to 77.6 years (Hahn et al., 1990). At the same time, new drug regimens and technologies offer the promise of lowering deaths due to major killers such as heart disease and cancer.

This success is based on several key features of the U.S. health care system.

Choice.—Individuals and families are free to choose their own physician and hospital and an increasing number of Americans are able to choose among a variety of health plans. This, in turn, encourages physicians, hospitals, and health plans to compete to provide better health care at a lower cost. As a result, our health care system reflects the needs and concerns of ordinary Americans as expressed in the choices they make. This dynamic should be nourished and strengthened.

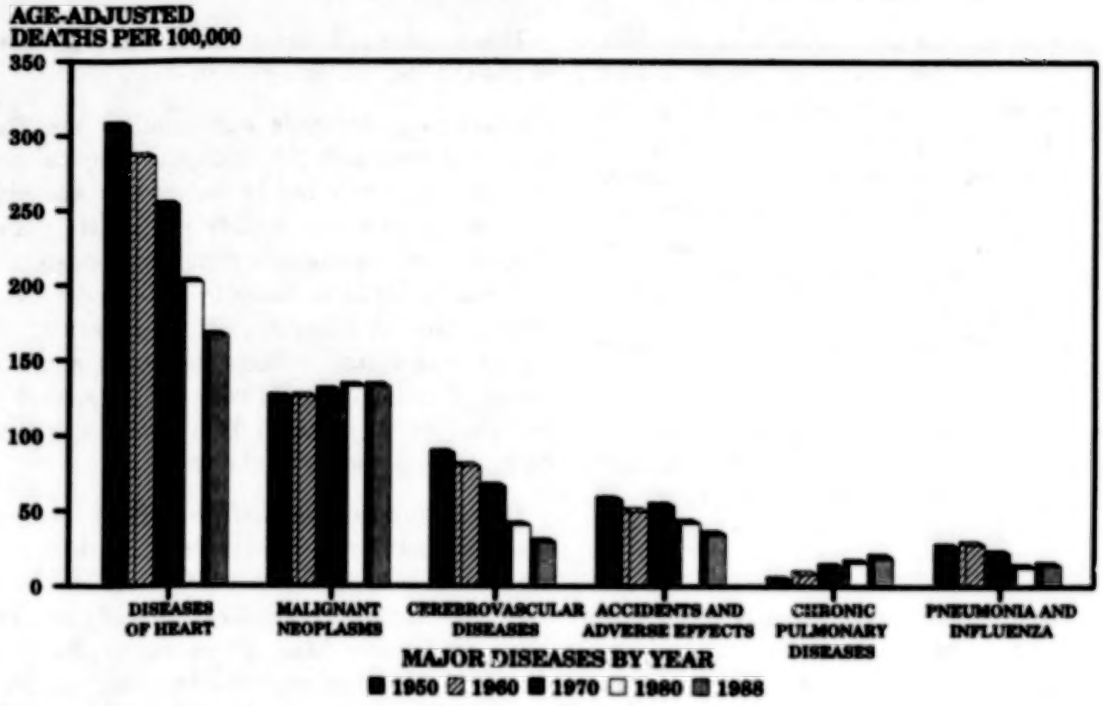
Diversity and Flexibility.—Choice and the open competition by providers for patient care also assures diversity and flexibility in the financing, organization and delivery of care. The last two decades have witnessed unparalleled innovation in the organization and management of health care in the United States. The most important development is the growth of coordinated care. Health maintenance organi-

Chart 7. LIFE EXPECTANCY IN THE U.S.



SOURCE: U.S. DHHS, "Health United States, 1990"; PHS, March 1991

Chart 8. MORTALITY RATES FOR SELECTED CONDITIONS, 1950-88



SOURCE: US DHHS, National Center for Health Statistics, "Health USA, 1990"

zations (HMOs) and preferred provider organizations (PPOs) now serve over 40 million Americans. These health plans combine the financing and delivery of health care and integrate quality management across the entire continuum of care—from prevention to care for chronic illnesses. Through competition, coordinated care plans are driven to respond to consumer needs leading to better quality care at lower costs.

Skilled Medical Professionals.—U.S. physicians and health professionals are the best educated and most skilled health care work force in the world. U.S. Hospitals and medical schools are world leaders for particular specialties and treatments.

Caring Volunteers.—Hundreds of thousands of groups and organizations engaging millions of volunteers assist in providing quality health care.

Health care volunteers improve access to health services and help to control health care costs. These volunteers provide such services as: working at community health clinics; caring for AIDS patients and their families; participating in drug abuse prevention, education, and rehabilitation; delivering meals to the homebound; providing hospice care; and assisting victims of debilitating diseases and supporting their families.

Biomedical Research.—The U.S. leads the world in biomedical research. America's continued dominance of the competition for Nobel prizes reflects that pre-eminence. Advances in biomedical research over the past four decades have improved the quality of health care while saving billions in health care costs. With an increasingly thorough understanding of basic disease mechanisms, researchers are likely to achieve additional breakthroughs within the next twenty years.

Federal investment in biomedical and applied behavioral research has increased as a proportion of GDP from 0.12 percent in 1970 to 0.16 percent in 1992. U.S. public and private funding provides the lion's share (Chart 10) of the funding for such research worldwide.

The Success of American Health Care—Examples

Cancer.—Deaths from childhood cancers have been reduced 38 percent since 1973, with almost two-thirds of children with cancer surviving beyond five years. There has been astonishing progress against Hodgkin's disease, with a 50 percent reduction in deaths, and against testicular cancer with a 60 percent reduction in deaths.

Heart attacks.—In the early 1960s, almost a million Americans a year died from heart attacks. Today, deaths from heart attacks have been dramatically reduced to less than half that number due to better prevention and better treatment. Major advances in treatment include therapy to dissolve blood clots that cause heart attacks and balloon angioplasty to relieve chest pain during convalescence and beyond. Patients are now commonly discharged after 8–10 days, and return to full activity within 4–6 weeks.

Hypertension.—High blood pressure affects 58 million Americans and can lead to heart disease and stroke. Since the National High Blood Pressure Education Program was launched in 1972, age-adjusted stroke mortality in the U.S. has declined by more than 50 percent. Recommendations from a recent study of hypertension in the elderly could further prevent 6 strokes and 11 major cardiovascular events a year per 1,000 seniors treated. Cost savings could total one-half billion dollars a year.

Diabetic Retinopathy.—Damage to the blood vessels of the retina from diabetes accounts for approximately 12 percent of the new cases of blindness each year. Until the late 1960s this condition was untreatable. Within the last two decades, laser surgery has been widely adopted as an effective treatment. By the year 2000, $2.8 billion dollars will be saved and 279,000 years of vision preserved as a result of this advance.

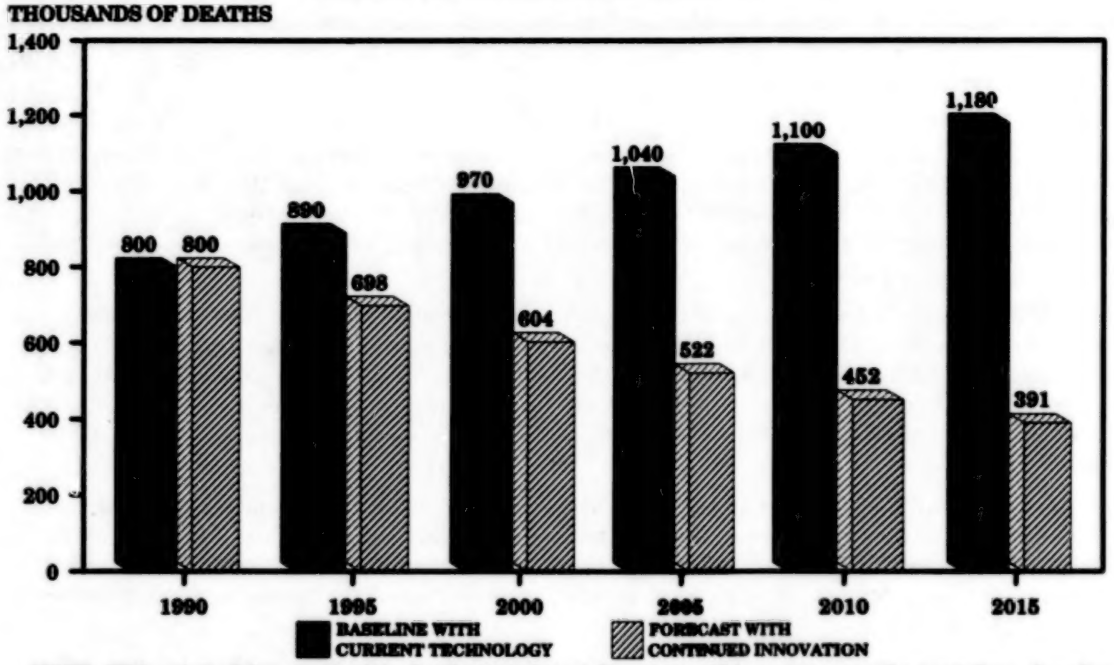
Paralysis due to Spinal Cord Injury.—This year 10,000 Americans—most of them young—will suffer a spinal cord injury, often resulting in life-long paralysis. Today, many patients recover thanks to a recently discovered treatment that involves high dose methylprednisolone therapy.

Technology.—Similarly, new technologies developed by the U.S. drug and medical device companies have grown exponentially over the last three decades. This innovation has improved the quality of health care for Americans and has strengthened our nation's international economic competitiveness. The U.S. accounts for nearly half of the $65 billion dollar global market for medical devices. Medical equipment exports have grown about 20 percent per year since 1985. In 1991, exports of such products reached nearly $7 billion.

A comparison with other prosperous Western nations—Canada and Germany—in Chart 12 presents some astonishing implications of the unparalleled access that Americans enjoy to sophisticated diagnostic and therapeutic technology. A difference in access to advanced technology is often the critical difference between health and disability, life and death.

Quality Assurance.—Finally, leadership in the development and implementation of new methods for assuring quality care has been a hallmark of health service delivery in the United States for over a decade. Peer review, practice guidelines, research on patient outcomes, and other activities mean that appropriate interventions are applied correctly to the individual's clinical condition.

Chart 9. PREDICTED DEATHS FROM HEART DISEASE WITH AND WITHOUT CONTINUED INNOVATION



NOTE: With aging of the population, deaths from heart disease would increase over the next three decades. But this increase can be dramatically reversed with continued technological innovation.

SOURCE: Ruth Brown, et al., "The Value of Pharmaceuticals," Batelle, 1991

Potential Future Breakthroughs in Medical Treatment

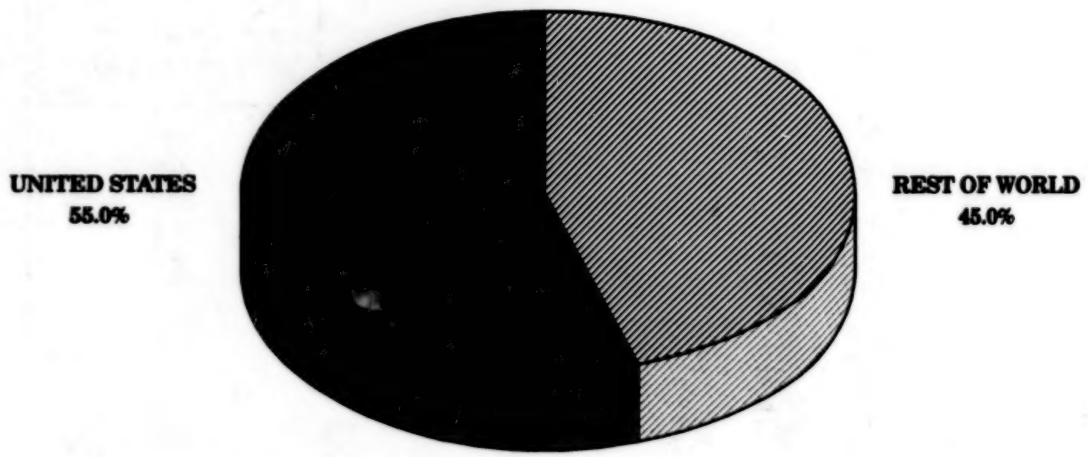
Cancer.—Despite recent progress, more than 500,000 Americans will die of cancer in 1992. There is, however, a new feeling of optimism among researchers. Clinical trials using a new drug, taxol, in women with breast cancer have shown very high response rates. Another new approach, use of chemotherapy before surgery can change an inoperable tumor to one that can be removed surgically. And there is potential for major advances in gene therapy and anti-cancer vaccines during the next 10 to 20 years

Alzheimer's Disease.—Alzheimer's Disease (AD) affects an estimated four million people in the U.S. at a cost of $90 billion a year. Aging of the population could result in a five-fold increase in the disease over the next fifty years. At present, there is no treatment. In the last 12 months, however, three major breakthroughs have occurred that give promise that research into the causes of AD will soon yield definitive results. This, in turn, is likely to lead to new concepts for developing treatments.

Cystic Fibrosis.—Over 30,000 children and young adults suffer from cystic fibrosis (CF). Discovery of the CF gene in 1989 led to a new understanding of the disease. Recently, researchers successfully used a cold virus to implant a normal human CF gene into the lungs of live animals. This advance is likely to lead to an effective gene therapy in the foreseeable future.

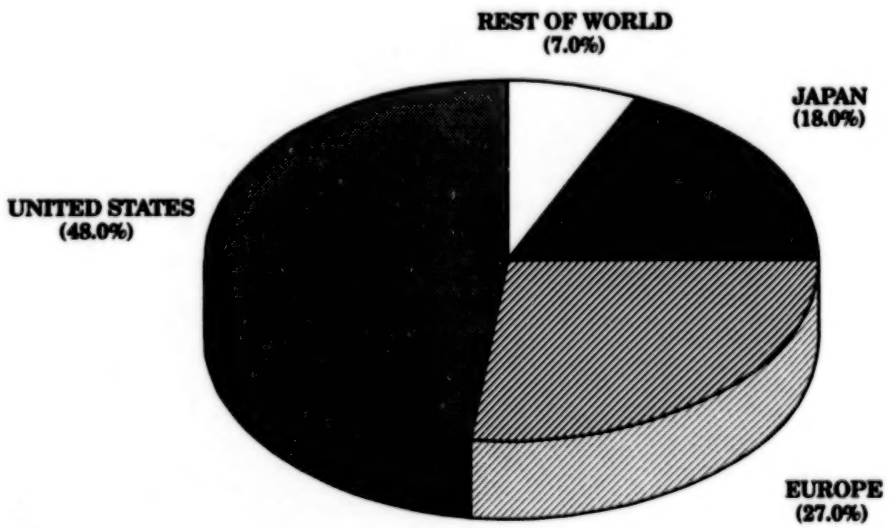
Diabetes.—Despite insulin, millions of diabetics are at risk of disabling complications. Transplanting pancreatic islet cells could "cure" the disease preventing these complications. Preliminary studies have successfully demonstrated that enclosing the transplanted cells in an artificial covering blocks rejection of the transplant by immune attack. A real cure for diabetes may be just a matter of time.

Chart 10. FUNDING FOR HEALTH CARE RESEARCH AND DEVELOPMENT, 1990



SOURCE: US DHHS/PHS/Office of International Health

Chart 11. PRODUCTION OF MEDICAL EQUIPMENT
UNITED STATES AND THE WORLD, 1991



SOURCE: Medicine & Health, January 27, 1991

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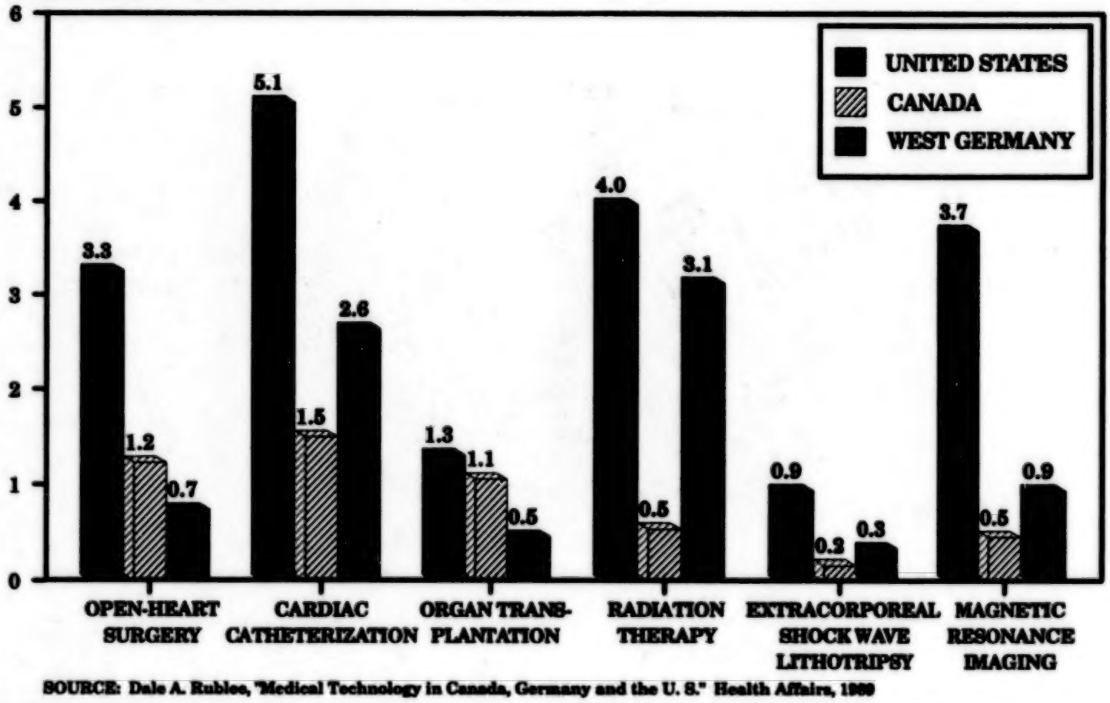
Chart 12. COMPARATIVE AVAILABILITY OF SELECTED MEDICAL TECHNOLOGIES



SOURCE: Dale A. Rublee, "Medical Technology in Canada, Germany and the U. S." Health Affairs, 1989

Chapter 3

Expanding Access and Increasing Affordability Through Market Reform

Overview

The President's proposal for reform of the health insurance market will make coverage more secure, available, and affordable for millions of Americans.

- Everyone—young and old, healthy and sick—will benefit from the assurance of the availability of affordable health insurance regardless of future changes in their health.
- Workers will be able to change jobs without fear that insurance coverage will be denied due to a preexisting illness.
- Premium costs will be reduced by as much as 20 percent for at least 70 million workers and their dependents affected by small group reforms.
- Five million Americans currently without health insurance will have insurance as a result of these market reforms.

The market reform proposal has four major components. These components will:

- Assure availability and security of coverage. Insurers would offer coverage without regard to health status. Coverage would be renewable, and preexisting condition limits would be eliminated. Employers would provide information and facilitate access to group coverage to all employees and dependents, but would not be required to administer or contribute to the cost of coverage. Further, colleges and universities would provide continued access to group coverage to recent graduates and other students for six months after leaving school.
- Assure affordability of coverage for individuals and small businesses through broad risk pooling. Insurers would participate in broad pooling arrangements to spread health risks evenly across insurers and thereby allow insurers to charge uniform premiums for the sick and the healthy. On an interim basis, pending phased implementation of this new system, insurers would be subject to limits on their ability to vary premiums.
- Encourage group purchasing of health insurance by small businesses to give them the same cost advantage enjoyed by larger businesses. Small businesses could pool their purchasing power through Health Insurance Networks (HINs). This will help small businesses negotiate discounts and save on overhead and marketing costs. Moreover, the Employee Retirement Income Security Act (ERISA) preemption that allows larger self-insured firms to avoid cost-increasing State laws will be extended to small businesses purchasing coverage through HINs. For the first time national and regional small business associations and other groups will also be able to establish inter- and intra-State HINs to better assist their membership.
- Give health plans increased flexibility to control costs. Health plans would be protected from mandated benefit and "anticooridnated care" laws that hinder designing cost-effective benefit packages to meet individual and family needs and drive up costs. Health plans would also be protected from laws and regulations that hinder innovative cost control measures, such as utilization review and selective contracting.

An important benefit of these reforms is strengthening significantly competition among health plans. In today's environment, health plans can gain a significant premium cost advantage by avoiding high risk individuals and groups. Under the Administration's reform

proposal, such "risk avoidance" will be stopped. As a result, competition will focus on price, value, and quality, leading to long-term gains in efficiency and improvements in quality.

Strengths and Weaknesses of the Current System

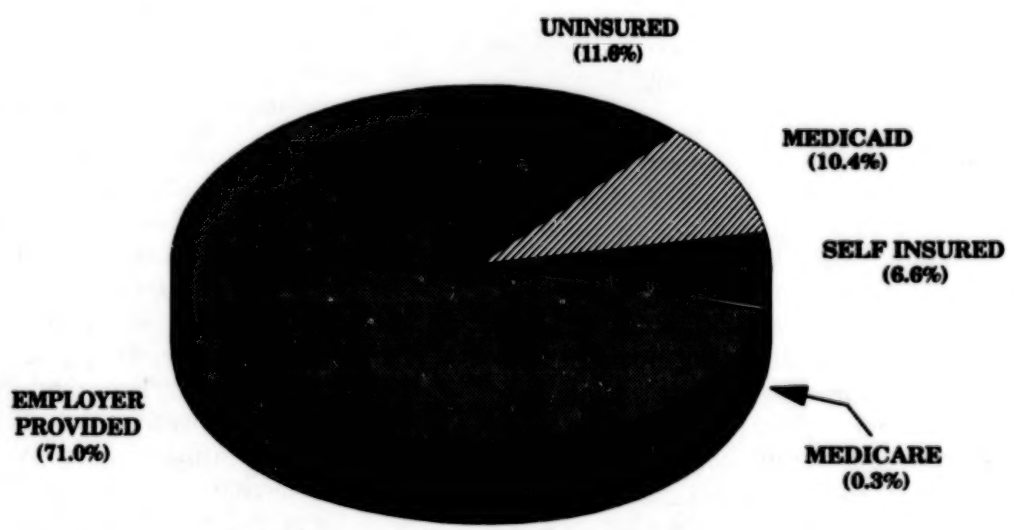
153 million working age Americans and their dependents—62 percent of the total population—are covered primarily through private health insurance. Most of these are covered through employment. This system has worked well because employment can be a stable basis for risk-pooling, particularly for medium and large firms and because substantial administrative savings and economies of scale are possible through employment-based group coverage.

Special Problems for Small Business.—While generally successful, there are significant problems with the current system, especially for small group and individual coverage. Workers at small firms are much more likely to be uninsured than workers at medium and large firms.

This disparity in coverage reflects three main problems. First, many small businesses cannot afford to provide costly fringe benefits. Second, health insurance is more costly for small businesses due to (i) higher overhead and marketing costs and (ii) costs resulting from State mandated benefit laws and premium taxes which generally do not apply to self-insured coverage ("ERISA exempt" from State insurance laws) typically provided by larger businesses. Finally, the market for health insurance for small business is in turmoil due to risk selection.

Erosion of Risk Pooling.—For people with serious illness, the cost of medical care can easily consume a substantial share of family income. With broad risk pooling, through insurance, the costs of illness are spread across a broad pool of premium payers, making costs more uniform, thus more affordable. The value of risk pooling is particularly great because spending on health care is highly skewed. At any given time, most of the population is healthy, and has little need for medical care. However, a small percent of the population is

Chart 13. INSURANCE COVERAGE OF THE POPULATION UNDER 65



SOURCE: Agency for Health Care Policy and Research, NMES, 1987

Table 3–1. Number of Uninsured Workers and Dependents By Establishment Size—1987

(Source: AHCPR, 1991)

Establishment Size	Number of Workers and Dependents	Percent of Workers and Dependents	Number Uninsured	Percent Uninsured	Percent of All Working Uninsured
Less than 25	74.2 m	44	17.2 m	23.1	68
26–100	34.6 m	21	4.3 m	12.3	17
Greater than 100	59.2 m	35	3.9 m	6.6	15
Totals	168.0 m	100	25.4 m	15.1	100

Note: Interventions affecting groups below a threshold, such as a hundred workers, will generally affect all *firms* below the threshold, as well as workers in establishments below that threshold, where firms have establishments in one or more States that fall below the threshold. Even limiting to the strict "firm"-based definition of size it is estimated that about 70 million workers and their dependents fall below a size of 100.)

seriously ill, and requires extremely costly care. The top 5 percent of the population in terms of health care use (i.e., the 95th percentile) have per capita health expenditures ($7,100) 26 times greater than costs ($270) for people at the midpoint of the population in terms of health care use (i.e., the 50th percentile).

Insurance risk pooling is valuable for everyone because even those who are healthy today may develop a serious illness at some point in their life. However, *risk selection* can undermine insurance as a pooling mechanism. Risk selection occurs whenever a particular pool has a skewed selection of risks. Such a pool will have a higher or lower average per capita cost when compared with other pools.

Risk selection is extremely difficult to prevent. This is because healthy and sick people have different needs for health insurance and choose different health plans to meet these needs. Generally, healthy people are attracted to leaner benefit packages (higher cost sharing, fewer covered benefits) because they expect that they will not have a need for more extensive coverage. In contrast, sicker people prefer richer benefit packages because of their expected needs. Moreover, certain features of coordinated care, such as a greater emphasis on preventive care, could be more attractive to the healthy. As a result, sick and healthy people will

Table 3–2. Distribution of Per Capita Health Spending By Age and Within Age Categories, 1987

(Source: AHCPR, 1991)
(In dollars)

Age	Mean	25th Percentile	50th Percentile	75th Percentile	95th Percentile
0–6 years	1,133	50	180	600	3,800
7–18 years	643	15	120	400	2,500
19–24 years	839	0	150	550	4,000
25–54 years	1,238	50	260	860	5,500
55–64 years	2,469	160	570	1600	11,424
Greater than 65 years	4,551	330	960	3,500	22,528
Total	1,591	50	270	1,000	7,100

sort themselves into different plans, even without any effort at selective marketing by insurers. The result will be that sick people will face high premiums due to the non-random distribution of health risks.

Risk selection is especially likely in the market for small group because a single small business cannot serve as a stable risk pool. One or two sick workers can greatly increase average per employee health benefit costs. Insurers originally combined many small businesses into a single risk pool and charged all members of the insured group a uniform (or age-adjusted) premium that did not vary based on health risk. This approach helped to make coverage affordable for individuals with chronic illnesses.

However, in today's market, some insurers have developed strategies for attracting low risk groups, while leaving higher-risk groups without coverage or with unacceptably high premiums. Favorable risk selection provides an opportunity to make a profit by offering low premiums to attract healthy groups while discontinuing coverage (or increasing premiums to a prohibitive level) once a group becomes more costly. Some insurers are also using medical information (health screening) to exclude higher-risk groups or individuals from coverage. Some insurers exclude preexisting medical conditions from coverage. In some cases, even individuals with relatively mild health problems have been denied coverage.

As some insurers succeed in attracting low-risk groups and avoiding high-risk groups, other insurers face an upward premium spiral, and must risk select to keep up with competitive pressures. Similar—possibly even more severe—problems affect the market for individual non-group coverage.

These problems are increasingly common. Moreover, there appears to be no natural end to current trends. Thus, if left unchecked, broad risk pooling seems likely to unravel in the small group and individual coverage markets. If this were to happen, health insurance would become unaffordable for many Americans—especially those most in need of coverage.

Assuring Availability of Coverage

The President's reform proposal contains several initiatives to assure that health insurance coverage is readily available. These reforms apply broadly to all private health insurance coverage regardless of group size and to coverage provided by employers who self-insure.

Prohibition on Exclusion from Coverage Due to Health Status.—All insurers wishing to sell group health insurance in a State would be required as a condition of doing business to (i) accept every employer group in the State that applies for coverage and (ii) provide coverage to individuals within an employer group. In addition, all employers would be prohibited from excluding any individual from health insurance coverage for reasons of health status. Finally, any insurer selling coverage to individuals receiving health insurance tax credits would be prohibited from excluding any credit recipient from coverage.

Guaranteed Renewability.—Insurers wishing to sell group coverage in a State would be required to renew coverage for a group except in the case of nonpayment of premiums, fraud, or misrepresentation.

Portable Access.—Under the proposal, workers would be able to change jobs without loss of coverage due to a preexisting coverage exclusion. Currently, some health insurance does not cover costs related to any illness or disease diagnosed prior to the initial date of coverage. As a result, many working Americans with chronic illnesses have been afraid to change jobs for fear that the insurance provided at their new job would no longer cover their medical expenses.

The use of preexisting condition exclusions would be eliminated. This will assure that all workers can change jobs without losing access.

Access to Group Coverage for Workers and Dependents.—All employers would be required to provide information on affordable basic health insurance plans available in their respective States. This information is to be prepared and provided by State insurance commissioners. This will expand access to plans that provide individual and family coverage to all employees—but employers would not be re-

quired to administer a health plan or make any contribution towards the cost of health coverage. States would assist employers by making available information regarding the availability and cost of "basic" coverage from various health plans. Employers would be required only to arrange for deduction of premiums from paychecks if employees so requested, but would have no other administrative burden. Health insurance networks—group purchasing arrangements for small employers—would facilitate this process and it is anticipated that most small employers would join a HIN (see below).

Access to Group Coverage for College Graduates.—To help fill a significant uninsured gap for new work force entrants, all colleges and universities that provide group coverage to students would be required to offer extended group coverage for new graduates and other students for six months after they leave undergraduate and graduate programs. The college or university need not make any contribution toward the cost of coverage under such a plan.

Assuring Access to Coverage for Individuals and Families Receiving Health Insurance Tax Credits (certificates).—Each State would define a "basic" benefit package or a series of packages with an estimated actuarial value equal to the value of the health tax credit. A number of benefits packages are provided as illustrative examples (*See* Table 3–3).

Any health plan in a given State could offer the State-defined "basic" benefit package to credit recipients and to others. To ensure that credit recipients have a variety of plans available, if no insurers offer the "basic plan" the State insurance commissioner could require two or more health plans with a substantial market share to offer the "basic" benefit plan. Health plans could charge a market price for the "basic" benefit package.

The State and Federal Governments would implement outreach programs with the goal of securing 100 percent participation among credit eligibles. Broader participation would help prevent unnecessary and costly emergency care by encouraging primary and preventative care.

Table 3–3. **Basic Benefit Plan Examples for Approximate Amount of the Full Health Insurance Tax Credit in 1993**

(Plans are illustrative only—States will design benefits)

"Coordinated" Fee-For-Service Plans

Plan A—Unlimited inpatient hospital, inpatient physician care, prescription drug coverage, 3 ambulatory physician visits and associated diagnostic services with a $10 co-pay per visit.

Plan B—Unlimited inpatient hospital, inpatient physician care, and 5 ambulatory physician visits and associated diagnostic services with a $10 co-pay per visit.

Plan C—Unlimited inpatient hospital, inpatient physician care, 10 ambulatory physician visits and associated diagnostic services with a $10 co-pay per visit.

Plan D—Inpatient hospital up to 15 days, inpatient physician, lab, emergency room, and ambulatory physician visits and associated diagnostic services covered for $5 fee per visit for the first three physician visits, then a 10 percent co-pay up to a $500 out-of-pocket limit.

Plan E—Includes all services under Plan D, but with a 20 percent co-pay on physician visits after 3 visits.

Plan F—Includes all services and co-payment under Plan E, but would offer prescription drug coverage.

Model HMO Benefit Plan

Plan G—Unlimited inpatient hospital and inpatient physician services, emergency room, and unlimited ambulatory physician visits with associated diagnostic services (subject to a $10 copayment), prenatal care, and prescription drugs (subject to a $5 copayment).

In cases where a hospital emergency room is an individual's first point of contact with the system, rotating assignment would be used to enroll an uninsured credit-eligible individual to a specific health plan if the individual were unable to make a choice. So for example, a homeless person entering the hospital and having no preference for any carrier would be assigned to an insurer by rotation and the credit would automatically flow to the insurer.

Assuring Affordability of Coverage Through Risk-Pooling

As noted above, broad risk pooling is essential if health insurance is to be affordable for the sick as well as for the healthy. The President's market reform proposal provides both interim and longer-term solutions. Transition measures, including "premium bands" would be implemented immediately to stabilize the small group market pending full implementation of longer-term measures.

In the near term, premium bands will spread risks within an insurer's pool by limiting the difference in premiums that an insurer may charge to groups with different health risks. This will make coverage less costly in the near term for higher risk groups. However, premium bands may be unstable in the longer term. Because an insurer would be unable to vary premiums to reflect fully actual differences in expected health care costs, healthy enrollees would have incentives to shift to other insurers that have fewer sick people in their pools.

Health risk pooling would assure affordable coverage over the long term both for small groups (under 100 employees) and for individuals and families receiving health insurance tax credits. Under this approach, health plans insuring a sicker than average population would receive a net transfer from the risk pool while other insurers will be net payers into the pool. This will assure stable risk pooling over the long-term and will level the competitive playing field among insurers to focus competition on efficiency and quality.

The health risk pooling approach would be implemented immediately for tax credit recipients and would be phased-in over a five year period for small group coverage. Delayed implementation in the small group market is appropriate to permit an orderly transition and to avoid undue disruption of existing arrangements. Immediate implementation of health risk pooling would, however, be possible for credit recipients since this is a new market.

Transition Measures for Small Group Coverage.—These transition measures would apply to all insurance provided to small businesses employing fewer than 100 workers. The premium standards (or "bands") limit variation in premiums within each insurance company's overall set of offerings. They would not constrain premium variation between insurers. The premium standards would be temporary and would be phased-out with full implementation of a system to equalize risk among insurers.

- *Premium Standards Across and Within Demographic Categories.*—Insurers could vary premiums by age. This means that younger workers would not be forced to subsidize older workers (who typically have higher income and higher health risks). But, insurers would be limited in their ability to vary premiums based on health status or prior use of care. Premiums could not differ by more than 50 percent within age/sex categories in the first year decreasing to 35 percent by the third year.
- *Rate of Increase Standard for Renewal Premiums.*—Insurers could not increase premiums excessively for groups with deteriorating health status or claims experience. The maximum percent increase in renewal premiums would be set at 5 percent plus the percent change in the "base premium rate." The "base premium rate" is the lowest premium the insurer could have charged under the relevant block of business for a group with similar demographic characteristics, excluding factors related to health status, claims experience, industry, occupation, or duration of coverage.
- *Premium Standards Across "Blocks of Business".*—Premiums could vary by up to 20 percent across different blocks of business. A carrier may establish different blocks of business: (i) for business acquired

from another carrier, (ii) for business obtained through a distinct system of marketing (e.g., brokers vs. associations), and (iii) for business obtained through different associations (for example, HINS). Carriers could establish three different blocks of business for each of the three reasons, for a total of nine different blocks of business.

- *Enforcement.*—An independent actuary would certify compliance. Failure to have a valid certification would trigger a violation. The State enforcement agency could conduct an investigation to verify certifications.

States could also implement a prospective reinsurance or risk allocation system on an interim basis to pool risks among insurers.

- Under a *prospective reinsurance* model, an insurer could obtain optional reinsurance for any group or newly eligible group member. The primary insurer would be liable for an individual's health costs up to a threshold amount. Above the threshold, the reinsurance program would be responsible for most of the cost. The program would be funded by reinsurance premiums and an assessment on all small group insurers.
- Under *risk allocation*, each insurance carrier would have a quota of assigned risks based on the carrier's market share. Insurers could initially refuse to provide coverage based on health risk. However, the rejected group or individual would have a right to select any insurer from an assigned risk list maintained by the State provided that the insurer's allotment has not been filled.

Health Risk Pools.—Each State would implement two broad health risk pools: one for small group coverage and another for coverage provided to individuals and families receiving transferrable health insurance tax credits. These pools would spread risk broadly across all health plans providing such coverage within a State.

Under this system, health plans that cover a sicker than average population would receive a net payment from the pool, while other health plans would be net payers into the pool. Payments from and to the pool would be based on the difference between the expected health care costs for the entire covered population and the expected health care costs for the population covered by the insurer.

As a result, insurers would no longer have an incentive to deny coverage to individuals with chronic disease. Moreover, insurers would be able to provide coverage at a near uniform premium for the sick and the healthy. The health risk pool would have this effect because a health plan that enrolls an individual with a high-cost chronic illness will receive a transfer of funds from the pool equal to the difference between the expected health care costs for the individual involved and the average expected cost. This moves the system back toward a flexible community rate—where choice in plans is maintained, but risk is truly pooled.

A number of methods have been developed for measuring expected health care costs based on the health characteristics of the population involved. These methods include the Diagnostic Cost Group system developed at Boston University and the Ambulatory Care Group system developed at Johns Hopkins. Other systems are available for use by the States. The Department of Health and Human Services would fund research to refine these systems and to develop improved systems for adjusting for health risk. The Department would also provide technical support to assist States in establishing the risk pools.

As is true for any system that varies payment according to health status, some degree of overreporting is possible, but such overreporting would not have an adverse effect on the pooling system unless some insurers were more successful at it than others. If necessary, to prevent this outcome, a random sample audit of insurance claims and other records could be used to verify the accuracy of health risk assignments.

The health risk pools for small group coverage and for credit recipients would be similar in most respects. Participation would be required for all health plans providing coverage to small groups and to credit recipients. If an individual purchases the basic benefit package, the insurance company re-

ceives the credit plus or minus an amount related to the individual's age (and possibly gender). These adjustments mitigate the problem of adverse selection for the basic benefit packages.

Amounts received by an insurance company would also be subject to health status adjustments. On an annual basis, each credit recipient would be assigned to a health status category. Each health category would have a corresponding weight based on expected health care costs defined relative to the population average. Each insurer would calculate an average weight for all credit recipients covered by the insurer. Insurers with an average weight greater than the statewide average would receive net transfers from the pool, while insurers with an average weight less than the statewide average would be required to make contributions to the pool.

States would implement pools for credit recipients simultaneously with federal implementation of the transferable health tax credit system. Implementation of health risk pools for small group coverage would occur over a five-year period on a phased-in basis, starting in the third year after enactment of the reform proposal. Transition measures, including premium limits, would apply in the small group market in the interval.

Encouraging Group Purchasing For Small Employers: Health Insurance Networks

The President's reform proposal will help reduce insurance costs for small businesses by encouraging group purchasing. Group purchasing can reduce health insurance costs by as much as 16 percent through efficiencies of scale, lower administrative costs, and through pooling of purchasing power that helps small businesses negotiate better rates with insurers.

Cleveland's Council of Smaller Enterprises (COSE) operates a successful health insurance group purchasing program for small firms. While COSE has been successful, surprisingly little of this type of group purchasing is going on nationwide. The reforms described in the preceding sections will spur group purchasing by protecting against some of the abusive practices that have daunted some local purchasing groups. Additional assistance is provided as well to encourage rapid formation of group purchasing arrangements.

ERISA Reform/Incentives for Group Purchasing.—The federal preemption of State regulation of self-insured health benefit plans under ERISA that benefits virtually all large employers would be extended to small businesses that purchase coverage on a group basis through a Health Insurance Network (HIN). This would protect against (i) State mandated benefit laws that require firms to provide certain costly services, (ii) excessive State health insurance premium taxes, (iii) and State anti-coordinated care laws. These laws typically increase premium costs by 2 to 5 percent. HINs could also still self-insure, but in this case, enhanced insurance State solvency and increased Department of Labor standards would apply to ensure the economic stability of the plans.

Functions.—HINs could contract with insurers to provide coverage to members or could self-insure subject to enhanced State solvency

Table 3–4. Savings From Small Market Reforms: Administrative and Bargaining Effects
(Expressed as percent of total premium, by firm size)

Firm Size Claims	Total Savings
<4	15.9
5–9	13.1
10–19	10.9
20–49	8.5
50–99	6.0

regulation (if State solvency standards are insufficient, Department of Labor solvency standards would operate as a backup oversight system). All federally approved HINs would be required to offer at least one coordinated care option and to use a standard claims form.

Organization.—HINs would be structured as non-profit voluntary membership organizations with a board of directors elected by the membership. HINs would be registered and qualified, as applicable, by a State agency or by the Department of Labor. There would be no limit on the number of HINs that could be established in a given area. HINs could be established along the lines of professional societies, industry, or trade associations and would be subject to all of the market reforms listed in the preceding sections. By buying coverage through a HIN, small businesses would be able to achieve more effective purchasing power in the market, thereby helping reduce the cost of insurance to their employees.

HINs will provide the mechanism for pooling large numbers of individuals and employees of small firms, an advantage that is now only available to large companies. These plans have not grown in the past because of State laws. To allow for federal preemption, plans had to "self insure". Small groups have difficulty raising capital to self insure risk. This system allows "imputed ERISA exemptions"—small firms can join together without self-insuring, and have insurers carry the risk.

Intrastate and Regional Pooling.—The State or Federal government could certify an HIN. For example, Pennsylvania (or the Federal government) could certify an HIN of 1,000 small employers who pooled market power to negotiate with local providers in Philadelphia, or the Federal government could certify a similar HIN for the Philadelphia area (PA, NJ, and DE) that would pool market power in the entire region.

Multi State Pooling.—HINs would allow for the first time, multi State pooling of small firms. Groups like NFIB, National Small Business United and The Chamber of Commerce (or any other group) could offer the same basic plans to members nationwide. In the past, State barriers have prevented such plans. This will simplify marketing and administration and sharply reduce costs.

Increasing Flexibility for Health Plans

States would no longer be allowed to mandate benefits that unduly limit flexibility for health plans, thereby increasing health care costs and restrict coordinated care.

State Mandated Benefits.—Many State laws require insurers to cover certain optional or ancillary services. These mandated benefits drive up premium costs up by at least 3 to 5 percent.

Provisions that Restrict Coordinated Care.—Some State laws impose restrictions which prevent the development of coordinated care—and the competitive pressure it imposes on fee-for-service providers. Anti-managed care laws include:

- *Restrictions on reimbursement rates or selective contracting:* Laws that restrict the ability of a carrier to negotiate reimbursement rates with providers or contract selectively with a limited number of providers.
- *Restrictions on differential financial incentives:* Laws that limit the financial incentives that a health benefit plan may require a beneficiary to pay when a non-plan provider is used on a non-emergency basis.
- *Restrictions on utilization review:* Laws that (a) prohibit utilization review of any or all treatments and conditions, (b) require that such review be made by an in-State physician or by a physician in a particular specialty, (c) require the use of specified standards of health care practice in such reviews, or require the disclosure of the specific criteria used in such reviews, or (d) require payment to providers for the expense of responding to utilization review requests.

Federal/State Relationships

Most of the reforms described in the preceding section would be implemented by the States. Thus, the responsibility for regulating health insurance would remain primarily with the States. However, federal legislation would be amended to provide States with clear

incentives to enact laws that will achieve national goals.In many cases, as with HIN certification and oversight, there would be backup federal certification and oversight procedures.

Under this approach, after an initial period to allow State action, if a State's health insurance laws do not meet prescribed federal guidelines, then insurance sold in-State would be certified through a federal back-up mechanism.

Other reforms would be implemented directly by Federal Government through amendment of the Federal Employee Retirement Income Security Act (ERISA) or through other appropriate legislation. Certification of HINs would fall into this category.

As stated above, federally certified HINs would be protected from State mandated benefit laws and State premium taxes in the same manner as an ERISA-qualified self-insured plan. Federally certified HINs would, however, be subject to additional State requirements to assure solvency. States could provide an alternative process for certification of HINs. If State laws and State premium taxes were excessive, a HIN could apply to the Department of Labor for federal certification—pre-empting State law. As a result, State would be encouraged to facilitate market pooling and access to coverage for small business—or risk losing their traditional insurance oversight and regulatory role to a federal backup system.

Chapter 4

Expanding Access Through Tax Measures to Help People Pay for Insurance: Health Insurance Tax Credit and Deduction

Overview

The cornerstone of the President's plan to increase access to health insurance is a new transferable tax credit and deduction designed to help most of the Nation's uninsured obtain health insurance. The plan places the highest priority on providing health insurance for low-income individuals, but also would provide substantial benefits to middle-income individuals who enjoy little or no employer contributions for health insurance and to self-employed individuals.

Policy Background

Current tax law provides substantial benefits to individuals whose employers contribute to their health care insurance costs. The entire amount of the employer's contribution is excluded from taxable income and from the FICA wage base.

Self-employed individuals are able to deduct 25 percent of their premium payments. And all taxpayers are able to deduct out-of-pocket medical expenses and premium payments to the extent that these expenses exceed 7.5 percent of adjusted gross income; however, this deduction is of limited value to most taxpayers because few have medical expenses significantly in excess of the AGI threshold.

Other federal programs—including Medicare and Medicaid—provide health insurance coverage directly to eligible groups including the elderly, disabled, and certain low-income individuals. However, many low income individuals—including many unemployed individuals and the working uninsured—do not qualify for any of these benefits and do not receive any direct or indirect Federal contribution to their health insurance.

Overall, there are estimated to be 34.7 million Americans without health insurance (CPS, March 1991). Lack of coverage has a number of adverse consequences. Health may be at risk because of reduced access to primary and preventive care. Moreover, uninsured people often seek medical care in hospital emergency rooms, which is costly and inefficient. The cost of providing care to the uninsured produces large cost-shifting within the health care system, increasing costs for the insured—by up to 15 percent for some services. For these and other reasons, expanding insurance coverage is an important goal for the Nation.

Analysts have suggested a variety of options as means of expanding insurance coverage. These options include national health insurance (see Chapter 6, section A), and a "play or pay" mandate to require employers

95 Million Americans Will Benefit

To make health insurance more affordable, the President's plan includes:

- A tax credit of up to $3,750 for low-income families;
- A tax deduction of up to $3,750 for middle-income families;
- An increase to 100 percent in the deduction for health insurance available to self-employed individuals.

to provide coverage or to pay a tax (see Chapter 6, section B). Both of these alternatives will lead to higher costs for American taxpayers, rationing of care, and inefficient delivery in an unstable system. The President's proposal instead relies on significant reforms of the health insurance market, a new transferable health insurance tax credit for low-income families, and a new health insurance tax deduction for middle-income families.

The President's plan will promote individual choice. With a system of health insurance tax credits and deductions, low- and middle-income families will be free to choose among a variety of health plans with increased availability due to the market reforms. This helps ensure that coverage meets individual and family needs.

Moreover, providing choice is a critical prerequisite of competition in any market system—and competition among health plans is the best way of assuring continuous improvements in quality of care, service, and cost-effectiveness. None of the alternative options for expanding insurance coverage promote choice or enhance competition. Indeed, they generally have the opposite effect. Other disadvantages are detailed more fully in Chapter 6.

Tax Credits and Deductions for Low-Income and Middle-Income Individuals

Low- and middle-income persons who are not covered by other federally subsidized health insurance programs will be eligible for a tax credit or deduction for the purchase of insurance.

Eligibility.—Eligibility for the credit or the deduction is related to income and extends up to a modified adjusted gross income of—

- $50,000 for single persons
- $65,000 for persons filing as heads of households, and
- $80,000 for married persons filing jointly.

These income levels will be increased to account for inflation.

Individuals who receive other federal support (e.g., covered by Medicare, Medicaid, CHAMPUS, and selected other federal health programs) would not be eligible for the credit. The transferable tax credit would replace the supplemental earned income tax credit available under current law for certain low-income taxpayers who contribute toward the purchase of health insurance coverage for their children.

Amount.—The maximum amount of the credit is $1,250 for single persons, $2,500 for married couples and other two-person families, and $3,750 for families of three or more. These credit amounts would be sufficient to purchase a basic health insurance benefits package (See Table 3–3). The amount of the credit would phase down to a minimum at increasing income levels.

Individuals, couples, and families may also elect to claim a deduction instead of the credit. The deduction will be available to persons without regard to whether they itemize or claim the standard deduction and will be equal to $1,250 for single persons, $2,500 for married couples and other two-person families, and $3,750 for families of three or more.

Both the credit and deduction amounts will be increased to account for inflation. Applicable credit and deduction amounts will be reduced by the amount of any contribution made by the employer to the employee's health plan. Individuals with employer contributions exceeding the applicable credit or deduction amount will receive neither the credit nor the deduction.

As noted above, the amount of the tax credit would vary based on modified adjusted gross income in relation to the tax filing threshold. The tax filing threshold is the sum of the standard and taxpayer and dependent exemptions and approximates the poverty level. Modified adjusted gross income equals the sum of adjusted gross income, plus nontaxable Social Security payments, Railroad Retirement payments, and tax-exempt interest.

The tax credit would be implemented over a five-year period. When fully implemented—

- All eligible individuals, married couples, or families with incomes below the tax threshold (100 percent of poverty) will re-

ceive the maximum credit (e.g., to $1,250, for individuals, $2,500 for married couples, and $3750 for families).

- All eligible individuals, married couples, or families with incomes above the tax threshold will receive a partial credit, decreasing to 10 percent of the maximum credit (e.g., to $125 for individuals, $250 for married couples, and $375 for families) at 150 percent of the tax threshold.
- All eligible individuals, married couples, or families with incomes above 150 percent of the tax threshold, will receive the greater of the minimum credit or the deduction of up to $3,750 as described above.

As noted previously, individuals, married couples, and families with incomes above $50,000, $65,000, and $80,000, respectively, would be ineligible for either the credit or the deduction. Also, as noted previously, individuals, couples and families could take the health insurance deduction instead of the credit. Moreover, the amount of the credit and the deduction would be phased out over the range of $40,000 to $50,000 for single persons, $55,000 to $65,000 for married couples and other two-person families, and $70,000 to $80,000 for families of three or more. The tax credit and deduction would cost about $35 billion in 1997 when fully phased-in.

Administration.—For filers, credits and deductions could be claimed on the tax return at the end of the year in the usual manner used for other credits and deductions.

Alternatively, low-income credit recipients could receive a transferable credit certificate during the year by applying to a governmental office. States may select a State agency, such as the Employment Service or contract with the Social Security Administration to certify applicants' eligibility and to notify the Internal Revenue Service of the issuance of the advance credit.

This mechanism would immediately qualify the individual or family for assistance in purchasing health insurance; people would not have to wait until they file their tax returns to benefit. Transferable credit holders would transfer the credit to an employer or insurer who provides health insurance in payment for coverage. The insurance provider will then reconcile the amount of the advance credit on their tax return.

Credits would be used to purchase a "basic" benefit package (or other health plans of their choice). States would ensure that insurance companies would make basic benefit plans available (See Chapter 3).

Tax Credits and Deductions for Self-Employed Individuals

The self-employed would be entitled to deduct 100 percent of the cost of their health insurance premiums or receive the applicable credit, whichever is greater.

Using the Tax Credit/Deduction to Purchase Insurance

The market reforms described in Chapter 3 would apply to help assure that coverage is both available and affordable for individuals and families receiving health insurance tax credits. Specifically, guaranteed issue, guaranteed renewability, and elimination of preexisting condition exclusions would all apply. Moreover, broad based health risk pooling would apply to insurance sold to credit recipients to ensure affordability of coverage for recipients with chronic illnesses. Finally, credit recipients would be able to buy low cost coverage through health insurance networks or HINs.

The initial credit amounts of $1,250, $2,500, and $3,750 for individuals, couples and families were selected to cover the cost of an efficiently-run health plan that provides "basic" services. Each State would define a basic benefit plan or plans that could be purchased for the approximate amount of the credit. Any insurer in the State could offer basic benefits to credit recipients. Credit recipients would be able to buy coverage other than the State-defined basic benefit package if such other coverage would better suits their needs.

Achieving the Goal of Expanded Access

The health insurance tax credit and deduction will help millions of low- and middle-income families afford health insurance. When fully implemented, approximately 86 percent of all individuals not receiving Federal medical

support have income in the range of eligibility for a credit or deduction; the remaining 14 percent are higher-income individuals or families.

- Individuals who have employment based coverage, but who pay much of the cost themselves, would receive a substantial new deduction or credit.

A total of 95 million individuals would benefit from the health insurance tax credit and deduction when the President's program is fully phased in.

- About 25 million low-income individuals would receive the maximum credit (adjusted for any employer contributions).
- Approximately 13 million individuals with incomes between 100 percent and 150 percent of the tax filing threshold would receive a partial credit or deduction.
- Finally, about 57 million middle-income individuals would receive a partial credit or deduction. Of these, 51 million would receive a deduction.

Self-employed workers would also be helped. In 1993, 3.1 million self-employed taxpayers currently buying health insurance would benefit from the increase in the deduction available to the self-employed. Still more self-employed individuals will benefit because they qualify for the health insurance tax credit. And, the insurance market reforms discussed in Chapter 3 will reduce the cost of health insurance for self-employed individuals at all income levels.

After five years, 29 million Americans will become newly covered. The number of uninsured will be decreased from 34.1 million to 4.9 million—or less than 1.8 percent of the total population. Twenty-four million Americans will gain coverage primarily as a result of the new health insurance tax credits and deductions. And, by reducing premium costs substantially, the health insurance market reforms and other cost-containment reforms will encourage employers to expand coverage voluntarily to an additional five million Americans.

Table 4–1. Effect of Overall Reform Proposal on the Number of Uninsured Americans

(People in millions; projected to population)

Income Level	Below 100 Percent of Poverty[1]	Between 100 and 150 Percent of Poverty[1]	Totals	As Percent of Total Population
Current Law Uninsured	15.4	5.7	34.1	12.8%
Covered Through Tax Credits and Deductions	14.9	5.0	24.1	9.1%
Covered Through Market and Other Reforms	0.4	0.6	5.0	1.9%
Total Newly Covered	15.3	5.6	29.2	11.0%
Remaining Uninsured	0.1	0.2	[2]4.9	1.8%

[1] Poverty here is the income level at which individuals, couples, and families must begin paying income taxes.
[2] Many of the 4.9 million remaining uninsured are eligible for a credit or deduction.

Chapter 5

Making the System More Cost-Effective

A. Overview

Over the past several decades, per capita health care costs in the United States have increased more than 4 percent per year faster than general inflation. Since 1960, real per capita health spending has grown as a share of GDP from 5.3 percent in 1960 to an estimated 13.1 percent in 1991. If current trends were to continue, total health spending could reach 26.1 percent to 43.7 percent of GDP by 2030 under alternative assumptions (Waldo et al., 1991). Clearly, these trends are unsustainable if the United States is to improve its economic base and standard of living.

This rapid growth reflects a number of factors that cannot easily be changed or controlled: the demographics of the U.S. population, the labor-intensive nature of health care services, and the introduction of beneficial—but highly costly—new technology. Other causes of rising health care costs—market failures in health care and health insurance—can and should be addressed through enhanced competition.

Currently, the mix of health services provided is not necessarily that which fully informed consumers would purchase under optimal conditions and services are not produced at minimum cost. A key issue is the role of insurance. While health insurance has important benefits—it protects individuals and families from unexpected high health care costs and it reduces financial barriers to care—traditional fee-for-service insurance with low cost-sharing stimulates over-utilization of services. The reason is straightforward: with insurance paying most of the cost, health care is perceived to be a free good for patients and demand for medical care increases above optimal levels. Moreover, insulated from the cost of care, consumers have little reason to shop for the best price.

More efficient forms of health insurance coverage are available. These include fee for-service coverage with modest cost sharing and coordinated care coverage, where the health plan strives to buy the best package of health care at the lowest cost on behalf of plan enrollees. Due to distortions in the health insurance market, however, demand has been relatively weak for these more efficient forms of coverage.

There are three principal distortions in the market for health insurance which support inefficient forms of coverage: (i) government subsidies which reduce consumer sensitivity to cost, (ii) opportunities for favorable risk selection—or "cream-skimming"—which can give inefficient health plans an unfair cost advantage, and (iii) limited consumer information regarding the quality of care in competing health plans which can lead consumers to mistake higher price (or more intensive service delivery) for better care or superior outcomes.

There are other weaknesses in our current system as well. Substantial consumer and provider uncertainty exists regarding the effectiveness of a broad range of alternative diagnostic and therapeutic procedures. Moreover, prevention often is neglected resulting in needless illness and greater cost. Finally, our current legal system increases health care costs by fostering "defensive medicine" and excessive litigation costs.

Against this background, the outlines of a comprehensive reform strategy become apparent. The key initiative is to shift health care delivery to a more market-based, competitive system. Other critical elements include reducing administrative costs, coordinated care initiatives, more prudent purchasing of care (particularly through public programs), prevention, and malpractice reforms.

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Each of these elements move the system toward greater efficiency. Together, these elements form the building blocks of a more fully integrated market-based system.

Strengthening Competition

The President's reform proposal has three main elements which will strengthen competition. These elements will lead to greater efficiency and a more equitable allocation of resources. The nature of competition will shift. Providers and the mix of services will be chosen based more on price relative to quality and meaningful outcomes.

Changes in Tax Policy.—The President's Plan contains two changes in tax policy that make health care moare widely available and affordable: (i) a transferable tax credit for low-income individuals and families, and (ii) a deduction for self-paid health premiums of up to $1250/$3750 for middle income individuals and families.

The transferable tax credit is a crucial reform. For the first time, government assistance for low-income individuals and families will be provided through tax credits rather than through a publicly administered health insurance program. Reliance on tax credits will allow increased consumer choice. Tax credits to low-income individuals will permit them to shop among plans and coverage options. Moreover, because the credit is set as a fixed dollar amount rather than as a percent of premium costs, consumers will be cost-sensitive and purchase additional coverage only when the benefits of such coverage at the margin outweigh competing goods and services.

Consumers affected by the tax credit and the capped deduction can be expected to be more cost-conscious. Restoring marginal cost sensitivity in this way could result in a 5 percent one-time reduction in health care costs for those affected (Chernick, Holmer, and Weinberg, 1987). This estimate is consistent with other studies which indicate one-time savings of between 2 percent and 13 percent (EBRI, 1989).

While these reforms will directly affect only a portion of the population, a broader spillover effect seems likely. Employers are likely to provide more efficient forms of insurance coverage to all employees—not just those directly affected by the change in tax policy. Because coverage does not correlate highly with income (Taylor and Wilensky, 1985), this spillover effect is plausible.

Non-medical areas will experience spillover benefits as well. By subsidizing health insurance for low-income workers, the tax credit will encourage re-entry into the work force—particularly for Medicaid recipients who may fear losing insurance coverage if they resume employment. Broader health insurance should also lead to productivity gains from improved health status for the uninsured unemployed/working poor.

Insurance Market Reforms.—The insurance market reforms will help make competition more effective as a means of encouraging greater efficiency. The market reforms will effectively block "cream skimming" or favorable risk selection. This will cause competitors to focus on cost-containment and quality. Group purchasing through Health Insurance Networks ("HINs") will also give small businesses greater market "clout." And, preemption of State-mandated benefit and anti-managed care laws will give health plans new flexibility to respond to market pressures for greater efficiency and cost savings.

Improved Information.—Comparative cost and quality information would be made available to purchasers through a new series of State and local initiatives. Providing this information is a critical element for a pro-competition reform strategy. Comparative information for individual and institutional purchasers will enable purchasers to shift demand towards high-value health plans and providers. This, in turn, will provide powerful incentives for plans and providers to compete by controlling costs while improving quality. Even a minority of well-informed consumers can influence other consumers and the direction of the market (Pauly, 1978). Plans and providers that demonstrate equivalent or superior outcomes at lower cost would gain a competitive edge. Service utilization and costs could be cut appreciably with no deterioration in outcomes.

Funding will increase for outcomes research. This research will better define the safety and effectiveness of key medical and surgical

procedures and will facilitate more appropriate use of costly technologies. Funding also will increase for efforts to develop practice guidelines for practitioners. By specifying a "best practice" approach for specific conditions, guidelines can help prevent unnecessary or potentially harmful care.

Administrative Savings

Some administrative costs (e.g., spending on utilization review) can result in net savings by identifying and preventing costly, unneeded, and potentially dangerous care. The U.S. leads the world in health care quality assurance. Quality assurance increases administrative costs, but adds important value for consumers.

Nonetheless, there are areas where overhead costs in the U.S. are excessive and savings are possible. One area of concern is administrative and marketing costs for health insurance sold to small businesses. Overhead costs can be as high as 40 percent of total premiums for small businesses compared with less than 6 percent for large businesses. Another area of concern relates to the high cost of paperwork associated with billings and claims forms.

Under the Administration's proposal, group purchasing arrangements, or Health Insurance Networks, for small businesses will help reduce administrative and marketing costs. And market reforms will reduce overhead costs by prohibiting insurers from refusing coverage to particular individuals in a group due to their health status and by discouraging frequent changes of insurers.

The Secretary of Health and Human Services is leading a number of initiatives to streamline administrative procedures. These include accelerated development of data standards for electronic claims processing, and encouragement of electronic medical records for insurance enrollees.

Coordinated Care

The President's reform proposal would encourage greater use of coordinated care arrangements through increased enrollment in public programs—Medicare and Medicaid—and eliminate State laws that hinder developing these arrangements.

"Coordinated care" refers to a diverse—and still evolving—set of alternative delivery models introduced over the last two decades. Examples include Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). Coordinated care plans offer the potential of: lower cost, improved outcomes through better quality assurance, and expanded consumer choice among health service delivery options. Coordinated care systems closely integrate the financing and delivery of health care. Unlike fee-for-service medicine, clinical decisions are coordinated across the full continuum of care.

Accumulating evidence presented in subsection B shows direct savings from coordinated care as high as 30 percent. Other studies show significant "spillover" savings: as coordinated care systems gain market share in local markets, fee-for-service costs are reduced as providers are forced to compete more vigorously. And, it is important to

Table 5–1. Savings From Small Market Reforms: Administrative and Bargaining Effects

(Expressed as percent of total premium, by firm size)

Firm Size Claims	Total Administration Savings	Total Savings with Bargaining Effects
Fewer than 4	12.6	15.9
5–9	10.6	13.1
10–19	9.1	10.9
20–49	7.4	8.5
50–99	5.5	6.0

stress that the cost containment potential of coordinated care is dynamic. Further savings are likely as management systems improve and as better techniques for delivering medical care are developed.

Prudent Purchasing in Public Programs

Expenditures for both Medicare and Medicaid programs have continued to grow at double digit rates. Medicare baseline growth for fiscal year 1992 is projected at 11.8 percent; expenditures under Medicaid have increased at nearly 25 percent on average over the last four years, making it the fastest growing domestic program. Prudent purchasing and other measures to improve efficiency could reduce growth in Medicare costs. Medicaid cost growth would be slowed by encouraging greater reliance on coordinated care and by providing States with greater flexibility. These savings will be achieved with no reduction in benefits for program recipients.

The Administration also supports measures to stop abuses in the current system. For example, payment for physician self-referrals would be prohibited under the Medicare and Medicaid programs. Physicians and other providers increasingly refer patients for tests or to diagnostic centers in which they hold some financial stake—a clear conflict of interest. Recent evidence indicates these "self-referral" arrangements can increase costs per episode by as much as 400–700 percent (Florida Cost Containment Board, 1991; Hillman et al., 1990).

Prevention

Prevention is a "win-win" investment. Health care costs can be cut while improving well-being and increasing worker productivity. Healthy behaviors can prevent between 40 and 70 percent of all premature deaths, a third of all cases of acute disability, and two-thirds of all chronic disability. Accordingly, the President's plan focuses on prevention efforts which have maximum return on investment. Specific initiatives include increased funding for: (i) vaccine research and other research targeted at preventing specific diseases; (ii) screening programs such as blood lead level testing, pap smears, mammograms, and blood cholesterol testing; and (iii) health promotion activities, such as campaigns to reduce smoking, increase seat belt use, or encourage early prenatal care for low-income women.

Medical Professional Liability Reform

Medical malpractice reform is a key element of health system reform. Malpractice premiums more than doubled from approximately $2.7 billion in 1984 to $5.6 billion in 1989. And, the threat of malpractice forces doctors to practice "defensive medicine"—ordering unnecessary tests and procedures simply as documentation to protect against litigation. Defensive medicine costs are estimated at about $21 billion a year. The current system also involves lengthy delays and excessive litigation costs.

To address these problems, the Administration is proposing comprehensive reform. States would be encouraged to reform medical malpractice litigation by: (i) capping the amount of allowable non-economic damages; (ii) eliminating joint and several liability for non-economic damages; (iii) eliminating the collateral source rule that allows for double recovery; (iv) requiring structured payments for malpractice awards, as opposed to lump sum payments; (v) promoting pretrial alternative dispute resolution to encourage reasonable settlements; and (vi) implementing procedures to enhance quality of care. These reforms would also be applied to Federal courts, and alternative means of resolving medical malpractice claims would be piloted within the Federal Employees Health Benefits Program.

In addition, the President's reform proposal supports amending State and federal rules of civil procedure to provide that a party who refuses to engage in alternative dispute resolution and who loses at trial must pay the other party's attorneys' fees. Finally, the Department of Justice will provide additional guidance concerning the application of the antitrust laws to certain aspects of the health care system.

Practice guidelines and standards of care have assumed growing importance in providing quality assurance. Such guidelines and standards also may play an important role in reducing defensive medicine. Their implica-

tions for malpractice litigation will be the focus of scrutiny by the Secretary of Health and Human Services.

Overall System Effects

Each of the individual elements will encourage greater efficiencies and a more fair allocation of resources across the U.S. health care system.

Tax policy changes, health insurance market reform, and greater availability of comparative value information will together generate increased cost sensitivity and increased consumer shopping across all income and occupational groups. Suppliers can be expected to respond with more affordable benefit packages and a more efficient mix of services. For example, use of cost-sharing and coordinated care plans could increase. As coordinated care plans achieve greater premium cost advantages, more individuals would switch to these plans from fee-for-service coverage. And, coordinated care plans would have incentives to increase savings by making provider networks more selective and by reducing marginally useful care, including cost-increasing technologies.

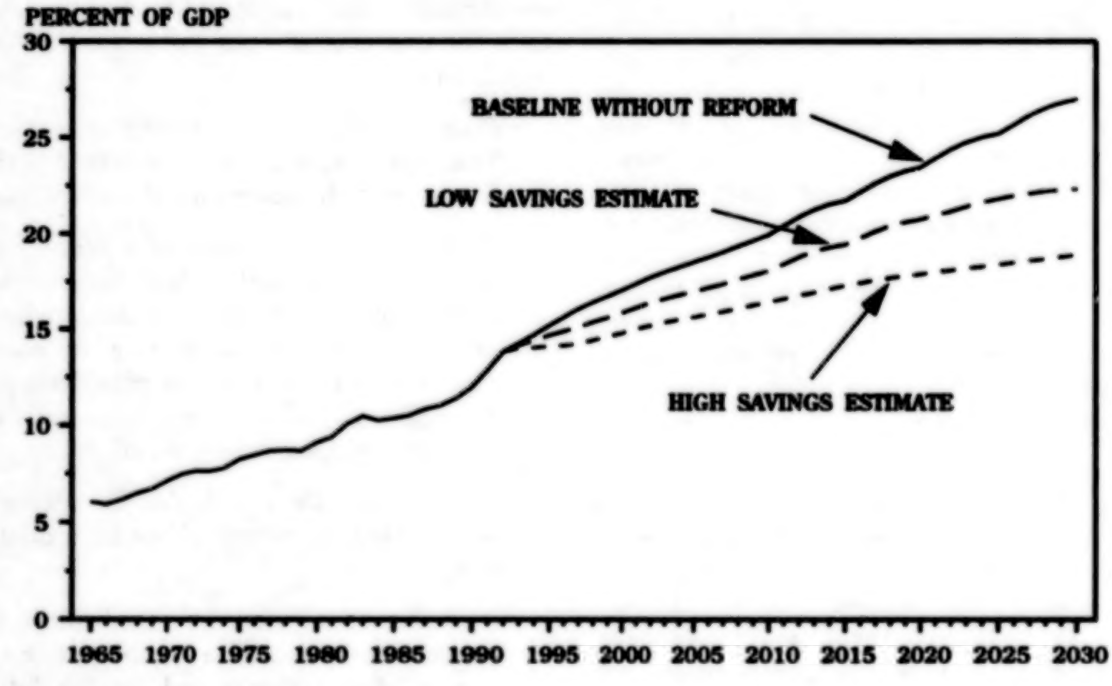
Increased use of coordinated care by Medicare and Medicaid would reinforce these market shifts. Public and private activity combined could make coordinated care plans the dominant system. The market power enjoyed by coordinated care approaches would further mean that norms of care (and consumer and physician expectations) would increasingly be established by this sector.

Projected Savings Estimates

The President's health care reform proposals can reduce the rise in health expenditures. The individual savings estimates, both static and ongoing, are presented in Chart 14. By 1997, total health expenditures could be cut by 6 to 14 percent if the proposals are adopted.

In dollar terms, projected system-wide savings through 1997 would total $394 billion. Projected estimates of cumulative savings

Chart 14. IMPACT OF HEALTH REFORMS ON PROJECTED U.S. HEALTH SPENDING



SOURCE: Office of Management and Budget

through the end of the decade total nearly a trillion dollars—$954 billion.

Over the longer term running into the next century, many of the President's proposed reforms can be expected to reduce the growth rate of real per capita medical expenses.

As shown in Chart 14, the long-term rate of growth in the Nation's health care costs can be cut from 10 to 19 percent. A lower growth rate in per capita costs, will eventually restrain the share of medical costs in the total economy. By 2030, the share of GDP devoted to health care will be 4 to 8 percentage points lower. Instead of 27 percent (the middle range projected estimate), it could be 19 percent.

Summary

Health care savings are to be achieved through implementation of the following reforms:

- Incentives for coordinated care;
- Making information available to consumers;
- Increases for prevention programs and higher levels of personal responsbility;
- Malpractice reforms;
- Reductions in administrative costs;
- Increased efficiency, reduction in waste, and increased cost-effectiveness of publicly funded programs.

The combination of these reforms will yield public sector savings that would be sufficient to offset the new health insurance tax credit and deduction.

B. Encouraging Coordinated Care

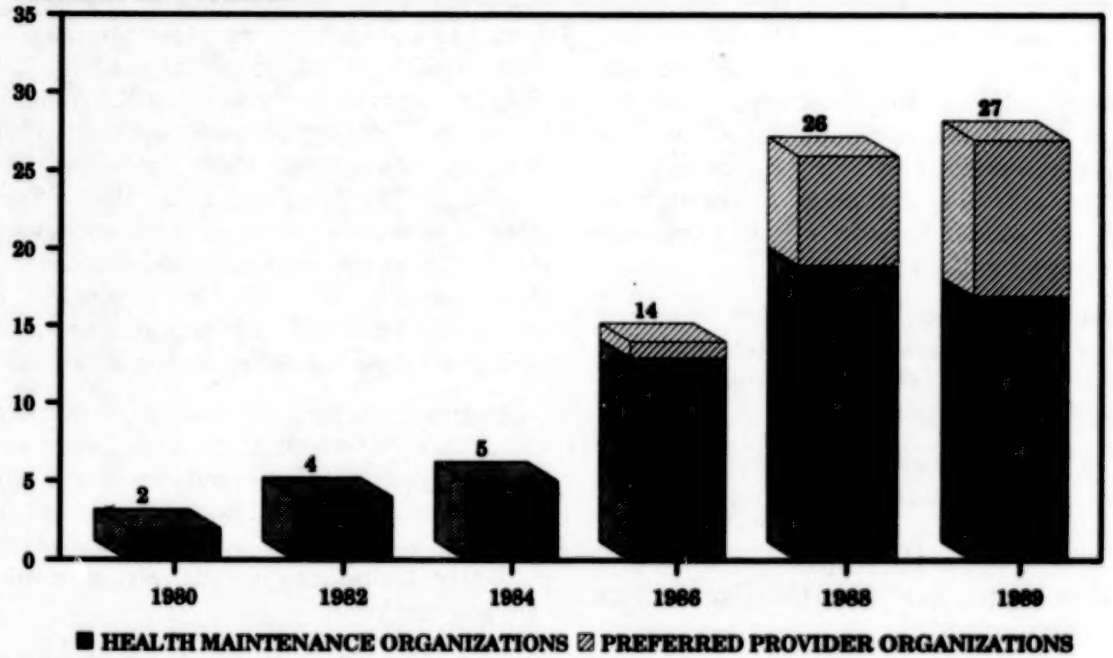
Overview

Rapid increases in health care costs have focused attention on the inflationary incentives inherent in fee-for-service and cost-based reimbursement, which traditionally have characterized American medicine. Under fee-for-service arrangements, physicians and other providers have incentives to perform more, not fewer, services, because practitioners receive higher levels of income by providing additional care. Many of these extra services offer little or no additional health benefit. Moreover, under these systems, health care delivery is often fragmented, with patients receiving services from different providers without any means of coordination.

In the past decade, health care delivery in the United States has been moving away from fee-for-service medicine toward "coordinated care" plans. The term refers to a diverse—and still evolving—set of delivery models that integrate the financing and delivery of care and alter the incentives for both providers and consumers of care. As Chart 15 indicates, by 1989, some 27 percent of workers in medium and large firms received care through a coordinated care arrangement as opposed to less than 2 percent in 1980. The trend is based on the realization that coordinated care systems offer better incentives for appropriate, less costly, high-quality health care.

- Coordinated care plans redirect incentives. The organization is placed at financial risk for the entire continuum of patient care.
- As a result, coordinated care plans have incentives to organize their systems and deliver care in the most efficient manner possible. Selective contracting to obtain discounts, exclusive use of providers, and provider payment incentives are approaches utilized to improve efficiency.
- Importantly, there are also incentives to ensure that the plans deliver high quality care:
  - —Unlike fee-for-service medicine, the plans are responsible for the entire episode of any illness and for the future welfare of the patient. Thus, plans have incentives to keep patients healthy and

Chart 15. COORDINATED CARE ENROLLMENT IN MEDIUM AND LARGE FIRMS



SOURCE: Interstudy, BLS Annual Survey

to ensure the most rapid and complete recovery from illness.

—An important byproduct is that plans have incentives to offer preventive services.

—Moreover, plans must maintain high standards of quality because plans compete for patients and patients can choose to enroll elsewhere.

Coordinated care plans employ a variety of mechanisms to ensure high quality care and coordination of services. These include utilization review to determine whether services are medically necessary and appropriate, pre-admission certification, second surgical opinions, patient case management, and the use of primary care physicians as coordinators and managers of care.

- Coordinated care plans are "win-win" organizations for providers and consumers. Consumers can receive high quality care with additional benefits such as preventive services. Efficiency gains can mean better returns for providers and lower premiums for consumers.

Models of Care

An array of coordinated care plans currently exist. A popular example is the preferred provider organization (PPO), in which a network or panel of providers contracts with the entity. Many consumers have favored PPOs because they allow greater freedom of choice in selecting providers. Typically, providers are reimbursed for services based on a negotiated fee schedule. Providers generally accept lower fees in exchange for directed access to increased numbers of patients. Utilization review programs ensure that physicians do not offset lower fees with inappropriately increased volume. Consumers may choose a provider outside the PPO network, but face additional out-of-pocket payments.

A second example is point-of-service (POS) plans that utilize a network of participating practitioners. Beneficiaries select a primary care physician, who makes all referrals for specialty care. If individuals seek care from a participating provider, they incur little or no additional costs. Individuals opting

to seek care outside the plan face higher deductibles and copayments.

A third well-known example is the health maintenance organization (HMO), in which a defined, comprehensive set of health services is provided to an enrolled group of individuals. The organization assumes financial risk for part or all of the group's health care. In the "group model" HMO, a physician group contracts with the entity at financial risk. Under the "staff model" HMO, physicians are employees of the HMO.

Perhaps not surprisingly, other countries such as Canada and the United Kingdom are now emulating the characteristics of coordinated care arrangements:

- The United Kingdom has recently implemented the most thorough reform of its system since its founding, by installing elements of market responsiveness by providers, especially by HMO-like private physician groups;
- Canadians are experimenting with "Health Service Organizations" which are similar to HMOs in concept but which do not always have the prepaid, locked-in enrollment features that can increase efficiency.

Evidence: Cost and Quality

Evidence indicates that coordinated care plans offer health care to enrollees that is as good as, or superior to that of fee-for-service medicine. Studies have generally shown comparable quality based on assessments of medical records between fee-for-service medicine and HMOs (Cunningham and Williamson, 1980; Luft, 1981). In addition, studies have shown that beneficiary satisfaction is very high in Medicare HMOs and equal to that found in Medicare as a whole (Rossiter, 1989). Moreover, Medicare HMOs offered more supplemental benefits, including preventive services, for a lower premium than that of traditional Medigap policies (which pay deductibles and co-payments not covered by Medicare). In general, HMOs have been able to reduce hospitalization and increase the use of primary care. A lower number of hospital patient days for coordinated care plans versus traditional fee-for-service results in substantial savings while ensuring quality care.

A number of studies indicate cost savings associated with the use of coordinated care (Luft, 1980; Luft, 1981; Manning et al., 1984, 1987; McCaffree et al., 1976; Luft, 1978; Roemer and Shonick, 1973; Wolinsky, 1980)—as high as 30 percent (Luft, 1981). Other studies (Dowd, 1986; Robinson, 1991; Rossiter, 1989; Scheffler et al., 1988; Welch, 1990) have shown "spillover" cost-savings into the fee-for-service sector as coordinated care plans increase their market share in an area and stimulate competition among a variety of plans, thereby driving down costs.

Evidence regarding cost savings from coordinated care is ongoing, in part because of the newness of plans and their changing organizational nature. Further savings are likely as management systems improve and as better techniques for delivering medical care are developed.

While there has been debate about whether some of the savings associated with HMOs can be attributed to favorable selection (i.e., healthier people enrolling in HMOs), the Rand Health Insurance Experiment (Manning et al., 1984) demonstrated that HMOs provide significant potential savings over fee-for-service medicine. Assessment of health outcomes between the HMO group and the traditional fee-for-service group showed no difference. In this multi-year demonstration in which individuals were randomly-selected into an HMO, reported savings over 5 years were as high as 25 percent, compared to patients randomly selected into fee-for-service arrangements.

Trends in Enrollment

Private Sector Growth.—The shift toward coordinated care over the past decade has been clear. As Chart 15 illustrates, in 1989 over 27 percent of all employees in medium and large firms receive care through HMOs or PPOs. The most significant growth has occurred in those coordinated care plans that offer consumers substantial flexibility to choose their own physicians.

Public Programs.—Enrollment in public programs has been less robust. *Medicare* began

to enter into fixed price contracts ("risk contracts") with HMOs in the mid-1980s. However, HMO enrollment has stalled since 1986, with risk enrollees only increasing from 1.0 to 1.3 million beneficiaries. Only 3 percent of Medicare beneficiaries currently are enrolled in alternative plans, in striking contrast with the under 65 population.

- The most serious problem is that the elderly have typically not used HMOs during their nonelderly years and have some reluctance to become involved in a new delivery system during a time when they can expect to become heavy users of health care. As more individuals with experience in coordinated care plans turn 65, this problem will diminish.
- A second problem is that HMOs have a limited ability to offer seniors a more attractive benefit package than what is offered by FFS Medicare. This is especially true for seniors (about 40 percent) who have employer-based supplemental benefits. These supplemental benefits can overlap with HMO-based benefits under Medicare coverage. Moreover, HMOs cannot offer cash rebates to seniors because they are prohibited from doing so by anti-kickback provisions. Nor can they lower Part B premiums.
- A third problem is that HMOs compete with a large, government program that has near monopsony power in most market areas. Medicare purchases FFS care for most of its beneficiaries and obtains deep price discounts due to its large market share. These price discounts may overwhelm potential savings that HMOs can obtain from discounts and better control over utilization.
- A fourth problem has been that HMOs are paid only 95 percent of comparable FFS costs (because of presumed efficiencies). Nevertheless, HMOs face marketing and enrollment costs unlike government. They further face greater financial risk on average due to full prospectivity, relatively small numbers of enrollees, and an Average Annual Per Capita Cost (AAPCC) payment methodology which currently fails to predict resource use and can fluctuate substantially year-to-year.
- A final problem is that until 1992, the only coordinated care option available to the elderly has been HMOs, a structure that is too rigid and inflexible for many Americans. As more flexible options become available, this could dramatically change their interest in coordinated care.

For *Medicaid*, HMOs have had legislative authority to enter into contracts with State agencies since 1967. However, Congress adopted measures in the 1980s inhibiting HMO contracting with Medicaid.

Current law authorizes use of new forms of alternative delivery arrangements, such as primary-care case management (with an appointed physician or other primary care provider serving as a gatekeeper to specialist and inpatient services) and health insuring organizations (a fiscal intermediary that functions much like the insurance portion of an HMO by providing strong utilization controls). This meant States had a variety of alternatives for testing the cost-effectiveness of Medicaid recipients into coordinated care plans.

By 1991, nearly two and one-half million Medicaid recipients across 28 States received care under coordinated care arrangements (Hadley and Langwell, 1991; Wilensky and Rossiter, 1991). Nevertheless, these gains in enrollment still account for less than 10 percent of Medicaid recipients nationally.

Increasing Incentives

The President's reform proposal emphasizes greater use of coordinated care arrangements through increased enrollment in the private sector and through public programs.

In the private sector, millions of Americans eligible for the transferable tax credit (certificate) would have the choice of enrolling in coordinated care plans offered within their State. Because of efficiencies of care provided by HMOs and other alternative delivery arrangements, premiums offered by these plans would be expected to be very competitive relative to traditional fee-for-service plans. From a quality and continuity of care perspective, plans could provide more primary/preventive and comprehensive benefits relative to fee-for-service plans.

Medicare and Medicaid.—Through the public programs, incentives for coordinated care will be pursued more aggressively. As Chart 16 demonstrates, the percent of Medicare and Medicaid recipients currently enrolled in coordinated care programs lags significantly behind private sector enrollment. Medicaid initiatives will be encouraged through increased State flexibility and federal matching rates that are based on a per capita basis—discussed in greater length in section G of this chapter.

Medicare is discussed in more detail here. HCFA will initiate a two-pronged approach because the only coordinated care alternative currently is the HMO option. Medicare will:

- create new options, as alternatives to the most structured form of coordinated care (HMOs), that would provide beneficiaries with greater provider choice while introducing them to the benefits of coordinated care; and
- take steps to strengthen the existing HMO option.

A summary of the individual initiatives are listed in the table below.

Creating New Options.—New options, such as Point of Service (POS) and Employer POS would be initiated. Under current law, a beneficiary who wants to receive benefits through an HMO must enroll with that plan. Beneficiaries enrolling in HMOs with risk contracts are required to receive all of the Medicare covered services through the HMO.

In recent years, employers have moved toward health plans where individuals make a choice at the point of service of whether to receive care through the plan's network of providers or outside that network. These plans have been popular with employees and have achieved the desired results of moving a significant percentage of services into the preferred provider network.

Under POS, HCFA would enter into multi-year contracts with POS contractors to create comprehensive preferred provider networks (primary care physicians, specialists, hospitals, labs, etc.) for beneficiaries not enrolled in

Chart 16. PUBLIC PROGRAMS LAG IN COORDINATED CARE

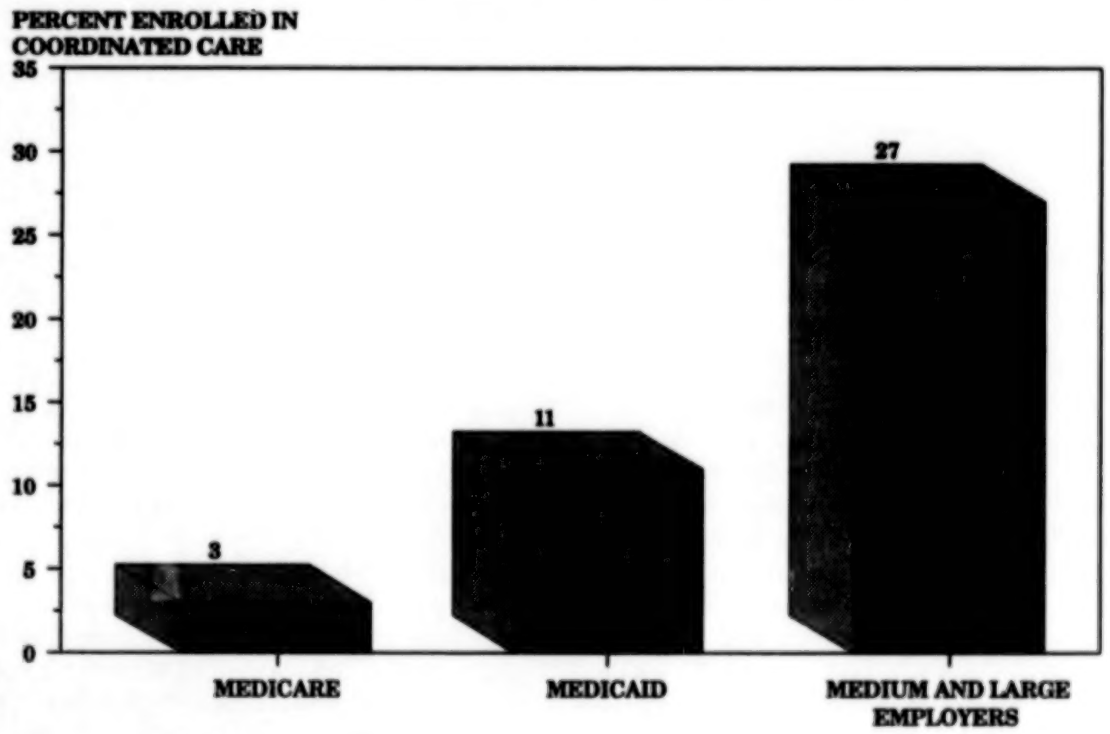


Table 5–2. Summary of Medicare Corodinated Care Initiatives

General Approach	Initiative	Features/Comments
Create New Options	Point-of-Service	multi-year contracts preferred provider networks negotiated discounts
	Employer	union/employer-sponsored plan
	Point-of-service	provide medical review/utilization review coordination of services/benefits
	Case Management	high cost/chronic cases voluntary plan of care medical/utilization review
Strengthen Risk-Based Program.	100 Percent AAPCC	2 options: (1) increase AAPCC payment (2) outlier payments/beneficiary rebates
	Reform AAPCC Methodology	(1) use USPCC to update rates in high penetration areas (2) experiment with competitive bidding approaches
	Increased Flexibility	(1) large group contracts (2) multi-year contracts (3) continuous open enrollment (4) comparative information materials
	Refine Current AAPCC Methodology	(1) working aged adjustor (2) health status adjustor
	Reform Cost Contract Options	advantage: introduces beneficiaries to plan option disadvantages: poor incentives for efficiency would over time phase-out
	Strengthen Oversight	expand sanction authority for: (1) prohibited marketing practices (2) illegal marketing material (3) non-compliance with quality review

risk plans. POS contractors would negotiate discounts for combined Part A and Part B payments for high cost/high volume surgical procedures. They would also negotiate other discounts from providers and suppliers. POS physicians would have incentives to make referrals only within the POS network.

For employer POS, HCFA would contract with employer or union-sponsored plans to provide medical review/utilization review (MR/UR) for Medicare covered services for retirees. This would enable employers and joint union/management Taft-Hartley trusts to coordinate benefits to retirees through the same administrative structure used to coordinate care for active employees and/or under-65 retirees.

Strengthening Existing Risk-Based Program.—For the longer run, the more significant initiative will be to strengthen the existing coordinated care program. The President's plan will initiate several actions that will increase investment in the current program.

For example, one important approach will increase payments to HMOs with risk contracts. This could either be done by (i) directly increasing payments from 95 to 100 percent of the AAPCC or by (ii) indirectly increasing payments to 100 percent through a combination of payments through an outlier pool and provision of beneficiary rebates.

Under the first option, the additional 5 percent AAPCC payment could encourage entry into the Medicare market of HMOs that currently are not participating. Existing plans could use the additional 5 percent to improve their competitive edge against Medigap plans by offering additional benefits or providing rebates to beneficiaries.

Under the second option, Medicare would make additional payments to HMOs through an outlier pool for a portion of the costs of high cost cases above a predetermined threshold. For example, if Medicare paid for 60 percent of the costs for cases that exceeded $61,000 in 1993, payments to HMOs would increase on average by 2.5 percent.

In addition to outlier payments, Medicare could provide rebates to beneficiaries enrolled in HMOs as a concrete sign of the support of the risk contract program. The rebate could equal 30 percent of the Part B premium.

A second general approach to strengthen the current program will be through reform of the current AAPCC payment methodology. Although the AAPCC methodology is accurate in predicting the costs for an HMO's total enrollment, its predictive power in regard to individual enrollees is extremely low.

Even though enrollment in risk plans as a percent of total Medicare enrollment is low, in some counties enrollment is greater than 25 percent. Over the past few years the increases in the AAPCCs for these counties has lagged behind the national average increase (USPCC). For example, while the national average increase in rates for the past three years was 22.6 percent, in one county with 34 percent enrollment the increase was 15.5 percent. In another county with 27 percent enrollment the AAPCC actually decreased over the past three years.

Several options are available such as (i) recomputing the rates for high penetration areas based on the growth in the USPCC rather than changes in the geographic factor, and (ii) experimenting with competitive bidding to establish payment rates.

Several other initiatives to strengthen the current risk-based program are not detailed here but are summarized in the table above.

Anti-Coordinated Care Laws

Currently, many State-based laws and regulations discourage greater use of coordinated care arrangements. Examples of these barriers include restrictions on reimbursement rates, restrictions on selective contracting for providers and services, restrictions against certain financial incentives arrangements, and utilization review activity. The President's plan would protect health plans from anti-coordinated care laws and regulations.

Second, federal waivers are currently applied to demonstrating and evaluating new coordinated care approaches, in effect designating them as exceptions to mainstream health care policies and practices. Under the President's Plan, these waivers of exception would be "flipped." States would have to apply for exceptions to coordinated care policies instead.

C. Providing Comparative Value Information for Health Purchasing

Background

Providing useful information for purchasing health care is a critical element for a pro-competition health reform strategy. Informed consumer choices should guide the delivery of medical care. In a market of coordinated care organizations, consumer choice could be exercised through selection of a health plan in which to enroll. With traditional fee-for-service coverage, consumer choice would be exercised through decisions about providers and procedures.

People now routinely make many decisions about insurance coverage and medical care. Strengthening competition through the tax credit and through health market reforms will encourage more direct comparisons with costs and outcomes—that is, assessing the value of their health care dollar.

Currently, meaningful information about comparative costs and outcomes is not routinely available to consumers. Consequently, consumers are unable to assess the value of their health care dollars by making comparisons of costs and outcomes across health

care providers and health plans. This lack of consumer information has potentially harmful effects on consumers and the Nation. Anecdotal information is unreliable.

As a result, consumers and purchasers of care often do not know what they are buying. In the absence of information, consumers are apt to rely on higher price or more intensive service delivery as proxies for quality. Thus, limited consumer information can insulate providers from competition and can lead to excessive prices and inefficient delivery of care.

Wider availability of cost and outcomes information will strengthen incentives for efficiency, especially when coupled with changes in government subsidies for insurance. Health plans that demonstrate equivalent (or superior outcomes) at lower premium cost would gain a competitive edge. Similarly, people want to know, for example, if Hospital A provides better care than Hospital B and would choose accordingly, if they could. Because consumers tend to mistake higher cost or more intensive service delivery as proxies for better quality, service utilization—and costs—could be cut appreciably with no deterioration if consumer choices were guided by valid cost in quality and quality information.

Through concerted public/private sector action, it should be possible to implement information systems that would enable health care purchasers to make meaningful comparisons of cost and quality between health plans and health care providers. The long-run potential to control costs while improving quality is substantial. Even a minority of well-informed consumers can influence other consumers and the direction of the market (Pauly, 1978). With better information, health plans that manage cost-increasing technologies could pass the savings on to purchasers. Cost-increasing technologies would be utilized only if consumers believe that the resulting improvement in health outweighs the added cost.

Comparative value information can change consumer decision making. For example, Washington Consumers' Checkbook, a magazine published by a nonprofit organization, illustrates that consumer's use of information changes market behavior. The Federal Employee Health Benefits Plan (FEHB) makes consumer choice relatively easy, and this is something of a model for improved consumer involvement. Since 1979, Washington Consumers' Checkbook has prepared an annual guide to federal plans in the Washington, D.C. area. The guide compares plan benefits, special features such as dental coverage or customer service, eligibility, premiums, and out-of-pocket costs, and draws conclusions on values. The results of the comparisons have influenced market share during each federal employee open season. For example, during the 1980 enrollment period, a plan that was ranked highly in terms of benefits relative to costs increased its Washington D.C. enrollment by 120 percent, compared with less than a 20 percent increase nationally.

More sophisticated prototype systems for comparing costs and quality are available as well. The Pennsylvania Health Care Cost Containment Council publishes information about what hospitals charge and comparisons of mortality rates for every hospital in the State.

This information allows consumers to learn, for example, that two hospitals within 40 miles of each another charge very different prices for the same procedure. For coronary artery bypass surgery, one hospital charged $17,490 while the other charged $28,059 in 1989.

The Council also calculates actual mortality rates and projected mortality rates following hospital stays for hospitals that take into account age and sickness when admitted, two of the many variables that determine how sick a population a hospital treats. This data shows that for the same two hospitals, the lower cost hospital had a lower mortality rate than expected and the higher cost hospital had a higher than expected mortality rate.

To encourage greater employee support for selective contracting and to provide hospitals with stronger incentives to improve quality while controlling costs, a group of major employers in Cleveland, Ohio, is sponsoring the Cleveland Health Quality Choice (CHQC) project. CHQC is developing a state-of-the-art system for measuring and comparing the quality of care in Cleveland-area hospitals.

The system will include a survey to measure perceptions of quality from the patient's standpoint and a system for measuring quality from a clinical standpoint. Patient outcomes (e.g., death and complications) in hospital intensive care units and for selected medical and surgical admissions will be monitored with detailed clinical adjustments to account for differences in severity of illness.

CHQC hopes to be producing quality reports on a routine basis starting in 1992. CHQC expects that participating employers would use this information to guide their health purchasing decisions. Employers would share this information with their employees to encourage use of the selected providers. While it will be several years before the full impact of the program can be assessed, and the Cleveland group must overcome many hurdles, use of outcomes data to compare quality is growing in its popularity and its impact.

Other systems for measuring outcomes have been developed as well. A consortium of HMOs is working with leading researchers from RAND corporation to develop indicators of quality that could guide consumers in selecting between competing HMOs. The MedisGroups system is routinely used by over 500 hospitals nationwide to monitor quality. And, the Health Care Financing Administration will begin to implement the Uniform Clinical Data Set (UCDS) system to monitor the quality of hospital care provided to Medicare patients in the Nation's hospitals.

Proposal

Under the Administration's proposal, each State would implement programs to help make comparative value information more readily available for health care purchasers. This initiative would be included as part of the health insurance market reform proposal.

States could develop information systems directly, as Pennsylvania has done, or could delegate this responsibility to private sector groups. States could give preference to local health care purchasing coalitions, such as the Cleveland Quality Health Choice coalition.

Within one year of enactment, States would develop and make broadly available information regarding average prices and costs for common health care services. Information could include mean and median prices and a measure of the variability across and within market areas. This information could be especially useful for large purchasers of care for preferred provider arrangements and negotiated discounts. Sufficiently discrete definitions (e.g., utilizing standardized professional codes like CPT–4 codes) of a broad range of representative services could be developed to permit meaningful comparisons.

Within five years, States would develop systems to provide comparative quality and outcomes data for health care purchasers and for consumers choosing health plans and hospitals.

The Federal Government would implement these information systems directly in the case of inaction by the State and would charge a user fee to defray the cost.

The Secretary of Health and Human Services (HHS) would develop prototype systems, such as Medicare's Uniform Clinical Data Set (UCDS), to facilitate data gathering and comparisons of outcomes. There would be an emphasis on experimentation to test different methods for gathering and analyzing outcomes and quality information. HHS would fund evaluations to determine the most cost effective methods (e.g., those methods that yield the most useful information at lowest cost).

When appropriate, national standards could be established to facilitate uniform data gathering that would facilitate analysis and comparisons across the Nation.

D. Encouraging Personal Responsibility and Prevention

Personal Responsibility

Reform of the U.S. health care system can neither be fully effective nor complete until there are basic changes in how Americans view responsibility for their own health. Individuals must choose, for example, to improve eating habits and increase exercise; to reduce consumption of alcohol and tobacco; to end substance abuse; to avoid the high risk behavior that spreads HIV; to seek the necessary medical examinations and vaccinations; to seek early prenatal care; to wear seat belts and take other necessary precautions; and to learn to resolve conflicts without resort to violence. Personal decisions about how to live may have the most important effect on the Nation's health and the cost of caring.

About half of the 2.2 million deaths which occur in the U.S. every year are potentially preventable, as are many of the illnesses that afflict millions of Americans. Many of the "risk factors" for these diseases involve freely-made individual choices. Better control of fewer than 10 factors—such as diet, prenatal care, exercise, the use of tobacco, alcohol and illegal drugs, and the use of seat belts—could prevent between 40 and 70 percent of all premature deaths, a third of all cases of acute disability, and two-thirds of all cases of chronic disability. Since the preservation of individual choice is a cornerstone of American democracy, disease and injury prevention must become individual as well as national priorities. In this, the Nation must encourage a culture of character, which actively promotes responsible behavior and the adoption of lifestyles that are conducive to good health.

Benefits of Taking Responsibility for Health.—Personal behavior can have a dramatic effect on the quality and length of life. Regardless of access and costs, families and individuals are and will remain our first line of defense in preventing illness. Indeed, any strategy for constraining costs must include a plan to reduce the need for medical intervention. The average American could live almost four years longer if currently available preventive measures were followed fully.

Public and private efforts to promote healthy behavior have already achieved dramatic results:

Smoking.—The Nation has witnessed a dramatic change in behavior as the incidence of one of the leading contributors to preventable deaths, smoking, has declined from 40 percent in adults in 1965 to 28 percent in 1990. This change was brought about through a combination of actions by individuals, private industry, health providers, and all levels of government.

Traffic Accidents.—Increased use of safety belts, declines in drunk driving, and better vehicle crashworthiness have cut the traffic fatality rate by 50 percent since 1973. If the traffic fatality rate had remained at the 1973 level, an additional 40,000 lives would have been lost in 1991 alone.

One of the most important factors in reducing the traffic fatality rate has been the growing use of seat belts and child safety seats. As shown in the accompanying chart, simply accepting the personal responsibility for using these safety devices has saved many lives. As people increase their use of seat belts, child safety seats, and air bags, the Nation will see more lives saved every year. Air bags will be installed in an estimated 90 percent of all new cars sold in the United States by 1995.

Heart Disease and Stroke.—During the 1980s, death rates declined for two of the leading causes of death among Americans: heart disease and stroke. Much of this progress is attributable to changes in behavior. The more than 40 percent decline in heart disease mortality since 1970 reflects dramatic increases in high blood pressure detection and control, the decline in cigarette smoking, and increasing awareness of the role of blood cholesterol and dietary fat. Stroke death rates, which have dropped by more than 50 percent in the same period, also reflect gains in hypertension control and reductions in smoking.

Investing in Prevention

Prevention is an important element of an increased emphasis on personal responsibility. Preventive practices are, by and large, simple, inexpensive and effective. Prevention makes sense for a number of reasons. Many preventive interventions are proven to be *cost effective.* And prevention is a good investment for the market place, resulting in fewer productive days lost and in reduced morbidity and cost to the health care system.

Costs of Preventable Health Problems.—There is ample research estimating the costs of illness and disability, in terms of diminished longevity, productivity foregone, and money spent treating illness and disability. These costs are particularly sobering when the illness or condition could have been prevented.

Prevention is Cost Effective.—In 1987, primary prevention and health promotion accounted for less than 5 percent of overall health care spending, yet there is mounting evidence that prevention is cost-effective.

Investing in Our Economic Future.—Disease prevention presents the opportunity to dramatically cut health care costs, prevent the premature onset of disease and disability, and help all Americans achieve healthier, more productive lives. Although the emphasis on prevention has led to overall health improvements, the U.S. is still burdened by preventable illness, injury, and disability. Injury now costs the U.S. well over $100 billion annually; cancer, over $70 billion; and cardiovascular disease, $135 billion.

Directions for Prevention.—In recognition of the clear advantages of aggressive prevention activities, the government is supporting and enhancing prevention programs with known benefit, and, through demonstrations, testing interventions for their efficacy and efficiency. The Federal Government spent over $8

Table 5–3. Preventable Health Costs

Health Problem	Years of Life Lost	Costs (in millions of dollars)
Cardiovascular Disease	15,000,000	135,000 (1985 $)
Alcohol Abuse	3,140,178	7,672 (1980 $)
Smoking	534,870	4,509 (1980 $)
High Blood Pressure	319,499	6,289 (1980 $)
Cholesterol	159,333	7,655 (1980 $)
Glucose Intolerance (Diabetes Mellitus)	133,627	5,239 (1980 $)
Cancer	18,000,000	72,000 (1985 $)
Injury	2,300,000	180,000 (1988 $)

Table 5–4. Return on Investments in Prevention

Preventive Activity	Savings per Dollar Spent	Total Savings per Year (in millions of dollars)
Immunization:		
Measles, Mumps, Rubella	14.40	0
Polio	10.00	400 (1990 $)
Hib	—	—
Prenatal Care	3.40	—
Universal Breast Cancer Screening (30 percent women age 65–74)	—	3,538 (2020 $)
Hypertension Screening and Effective Followup	—	80,000 (1986 $)

Note: "—" means not available.

Table 5–5. Social Costs of Preventable Risks

Disease or Condition	Preventable Risk Factors	Lives Lost (1988)
Heart Disease	Tobacco use, obesity, elevated blood pressure, elevated cholesterol, sedentary lifestyle.	765,156
Cancer	Tobacco use, improper diet, alcohol abuse, environmental exposures.	485,048
Cerebrovascular Disease	Tobacco use, elevated blood pressure, elevated cholesterol, sedentary lifestyle.	150,517
Unintentional Injuries	Safety belt nonuse, alcohol abuse, home hazards	97,100
Chronic Lung Disease	Tobacco use, environmental exposures	82,853

billion for prevention in fiscal year 1992. This will rise to nearly $9 billion in fiscal year 1993. These programs fall into three basic categories: (i) measures to help vulnerable populations at high risk of preventable disease, (ii) measures to make primary care more readily available to disadvantaged or geographically isolated Americans, and (iii) measures to encourage healthier lifestyles.

Helping Vulnerable Populations

Table 5–6 describes the substantial funding increases proposed in the President's fiscal year 1993 budget for prevention programs.

- *Childhood Immunizations.*—Childhood immunizations are among the most cost-effective prevention activities. A $1 investment in Measles-Mumps-Rubella (MMR) vaccine may return $14 in averted medical care costs. Other routinely administered

Table 5–6. The Budget Provides Substantial Increases for Programs Focused on Prevention and the Next Generation

(Obligations in millions of dollars)

Initiative	1989 Actual	1992 Enacted	1993 Proposed	Percent Change: 1992 to 1993	Percent Change: 1989 to 1993
CDC Childhood Immunization	141	297	349	+18%	+148%
Infant Mortality Reduction	5,681	7,950	9,365	+18%	+65%
(Healthy Start)	—	64	143	+123%	N/A
Women, Infants, and Children Nutrition Assistance (WIC)	1,929	2,600	2,840	+9%	+47%
Head Start	1,235	2,202	2,802	+27%	+127%
Access to Primary Health Care Services	4,184	6,334	7,643	+21%	+83%
(Community/Migrant Health Centers)	482	594	684	+15%	+42%
(National Health Service Corps)	48	100	120	+19%	+150%
Nutrition Education	138	152	178	+17%	+23%
Breast and Cervical Cancer Mortality Prevention	—	416	515	+24%	N/A
Smoking Cessation	78	106	111	+5%	+42%
Physical Fitness and Diet	68	100	102	+2%	+50%
Injury Prevention	1,482	1,862	2,026	+9%	+37%
Family Planning	333	461	498	+8%	+50%
CDC Lead Poisoning Prevention	—	21	40	+90%	N/A
Tuberculosis Control	21	32	66	+106%	+214%

vaccines such as Diphtheria-Tetanus-Pertussis (DTP) and Oral Polio are reported to have similarly high rates of return. Through coordinated efforts at all levels of government and the private sector, the Nation has achieved a 98 percent immunization rate for children entering school.

The President's initiative will increase federal support to target efforts toward raising immunization levels in inner cities and other areas where health returns on these activities are certain to be high.

- *Healthy Start/Infant Mortality Prevention.*—The Nation's infant mortality rate continues to decline, having reached its lowest level ever (9.1 deaths per 1,000 live births) in 1990. But while the overall infant mortality rate continues to decline, mortality for African-American infants remains twice that for white infants—demonstrating the need for more intensely targeted assistance.

  Additional investment in prenatal care and nutritional assistance targeted to low-income women also continues to yield high returns. Overall, nearly 25 percent of all women and nearly 40 percent of African-American and Hispanic women do not begin prenatal care during their first trimester of pregnancy, the most crucial time for prenatal care. Investment in prenatal care can yield significant returns: each dollar invested in prenatal care for high-risk women might save $3 in treatment costs.

  The President's initiative proposes over $9.3 billion for all federal activities to reduce infant mortality, including $143 million for Healthy Start, an important program that targets federal resources to 15 areas with exceptionally high rates of infant mortality.

- *Women, Infants, and Children Nutrition Assistance (WIC).*—The proposal continues the President's strong commitment to WIC with the largest one-year increase ever proposed for the program, $240 million (9 percent), for a total of $2.84 billion—sufficient funds for full participation by eligible pregnant women and infants. A recent evaluation of the Special Supplemental Food Program for Women, Infants, and Children (WIC) found that for each dollar spent on nutritionally at-risk pregnant women and infants, Medicaid spending fell by between $1.92 and $4.21 during the first 60 days after birth.

- *Head Start/Early Childhood Development.*—Head Start provides a range of comprehensive early childhood development services, including education, nutrition, health and other social services. Children who enroll in Head Start experience immediate gains in cognitive growth, social development, and health status. For every dollar invested, Head Start may eventually save $6 in averted costs associated with special education, crime, and income support.

  The President's initiative contains the largest single-year funding increase in the history of Head Start, proposing an additional $600 million for a total of $2.8 billion. With the Administration's proposal, Head Start will serve an estimated 157,206 more children in 1993. This unprecedented increase in Head Start supports participation of all eligible and interested disadvantaged children for one year, complementing the 36 States (plus the District of Columbia) which also support pre-school programs.

  The President's initiative also proposes $850 million for the child care and development block grant, which was part of the child care legislation that the President proposed and subsequently signed in 1990. Low-income families receive vouchers they can use with the child care provider of their choice; block grant funds provide additional early childhood development services for pre-school age children.

  The proposal further includes $6 million for a new initiative in HHS to use local schools as a way to bring primary health care services to children from low-income families who might not already have access to these services. These "Ready to Learn" grants will enable community health centers and local schools in selected low-income communities to provide health outreach services through local schools.

- *Lead Poisoning Prevention.*—Lead poisoning is the most common environmental disease of young children, disproportionately affecting poor, minority children in the inner cities. Yet childhood lead poisoning is preventable through detection and abatement. This initiative includes $40 million to support about 30 Statewide lead poisoning screening and referral programs.

  In addition, the Department of Housing and Urban Development (HUD) will continue assisting low- and moderate-income private residential property owners abate lead-based paint by providing grants to States and localities. HUD's public housing modernization program will continue lead-based paint testing and abatement activity in public housing. Approximately $50 million will be spent on these activities in 1993.

Expanding Cost-Effective Primary Care

- *Access to Primary Health Care/Expanding Community Health Centers.*—Comprehensive primary health care services include diagnosis and treatment as well as education designed to encourage healthy behavior. Continued investment in improving access to primary health care is important to many communities and can yield sizable returns. Increased access in low-income communities can improve overall health status and reduce the use of emergency services.

  To put primary health care services within the reach of people who do not currently have adequate access, the President's 1993 initiative includes an additional $1.3 billion for programs supporting primary and preventive health care.

  The initiative also contains $120 million for the National Health Service Corps (NHSC). This 19 percent increase will enable the NHSC to expand the program and train additional physicians to provide health services in low income and underserved areas, increasing the availability of primary case—particularly in low-income underserved areas.

- *Breast and Cervical Cancer.*—Despite increasing federal investment in breast and cervical cancer screening, NIH predicts that over 45,000 women are expected to die from these two diseases in 1993. The key to successful treatment of breast and cervical cancer remains early detection. The sooner treatment can begin, the greater the chance of survival.

  The President's initiative will invest $515 million for screening through the Medicare program and through the Public Health Service. This investment will focus resources on screening low-income, high-risk women in age groups for which screening is recommended.

- *HIV/AIDS Funding.*—Under the President's initiative, total federal HIV/AIDS funding increases by 13 percent, to $4.9 billion.

- *Tuberculosis Control.*—The Nation has made great strides toward eliminating tuberculosis (TB). The disease has been curable and preventable for almost four decades. The long-term decline in TB morbidity enjoyed by the United States ended, however, in 1984.

  The President's Plan attacks the recent growth of TB levels head on. The initiative includes a 106 percent increase over 1992 for CDC Tuberculosis Control Grants.

Promoting Lifestyle Changes

- *Smoking Cessation.*—Smoking during pregnancy retards fetal growth, reduces birthweight, and doubles the risk of having a low-birthweight baby. Studies have shown a 25–50 percent higher rate of fetal and infant deaths among women who smoke during pregnancy compared with those who do not. Each dollar invested in smoking cessation for pregnant women may yield as much as $6 in averted costs for neonatal intensive care and extended care for low-birthweight infants. Beyond the damage tobacco use during pregnancy may cause, smoking is also a factor in the deaths of over 400,000 Americans every single year.

  The President's initiative expands smoking cessation education activities for specific at-risk populations, including minority and low-income pregnant women.

- *Injury Prevention.*—Every one percent increase in seat belt use saves more than 160 lives per year. If the U.S. were to increase the national average of seat belt use from the 1990 rate of 48 percent to the Administration's goal of 70 percent by the end of 1992, 3,800 lives could be saved annually and 100,000 injuries could be prevented—yielding potential economic benefits of $2.5 billion.

  The initiative increases funding for injury prevention to almost $2 billion, a 9 percent increase over 1992. These funds will be used primarily within the Department of Transportation (DOT) for aviation, rail, highway, marine, and pipeline and hazardous material transportation safety. An estimated 50,000 lives are lost annually in incidents in the transportation sector. The initiative also includes increased emphasis on reducing drunk driving and increasing occupant protection.

- *Family Planning.*—Evidence attributes reductions in infant mortality achieved over the last 20 years in part to effective family planning. Recognizing the importance of these services, the President's initiative contains an additional $37 million for HHS family planning grants and federal Medicaid payments, an increase of 8 percent.

- *Physical Fitness and Diet.*—The President's initiative for 1993 increases funding for health education, disease prevention, and physical fitness activities. It also focuses on bringing health promotion and disease prevention activities to older Americans. The Administration on Aging will provide more health risk assessments, nutritional counseling, group exercise programs and other health promotion activities. These activities can improve the health and quality of life of older Americans and allow many older people to receive these services regularly.

In summary, to confront the problems of access to health care and the continued escalation in health care costs, efforts are underway to address the problems of the uninsured and the underinsured and to tackle the country's growing health care expenditures. No matter what path is ultimately chosen, it is clear that prevention will play a critical role in the future health of Americans. It is also apparent that prevention can only be accomplished in partnership among individuals, the business community, and government.

E. Malpractice and Antitrust Reform: Changing Incentives for Provider Behavior

Our legal system distorts health care delivery in America. These distortions derive in part from perverse incentives that encourage malpractice litigation. Unnecessary and costly defensive medicine has increased. Fear of antitrust liability has helped produce an often inefficient and duplicative distribution of sophisticated services and equipment. Finally, the quality of health care is diminished by the reluctance of professional review boards and hospitals to discipline poorly performing physicians because of potential antitrust liability.

Proposal

In May 1991, the President proposed the "Health Care Liability Reform and Quality of Care Improvement Act" to address the costs of malpractice insurance, the transaction costs of malpractice litigation, and the length of malpractice dispute resolution proceedings, and to reduce the incidence of malpractice through increasing the quality of care.

The Administration's reform package includes proposals that encourage States to:

- Cap the amount of allowable non-economic damages. In the 26 States that have limited total damages, malpractice rates have declined significantly;

- Eliminate joint and several liability for noneconomic damages;
- Eliminate the collateral source rule that allows for double recovery;
- Require structured payments for malpractice awards, as opposed to lump sum payments;
- Promote pretrial alternative dispute resolution, including mediation and pretrial screening panels, to encourage reasonable settlements;
- Implement procedures to enhance the quality of care.

Additionally, at the Federal level the Administration proposes to apply these tort reforms to Federal courts to begin a pilot program in the Federal Employees Health Benefits Program that offers alternative dispute resolution; and to improve the quality of medical care through enhanced effectiveness research and improved peer review.

The proposed Act is based on three principles:

- Medical malpractice reform should seek both improved quality of care for patients and lower litigation costs.
- Legal reforms should reduce the incentives for physicians to practice unnecessary defensive medicine or to abandon practice in inner city and rural areas.
- Incentives for states to act are preferable to Federal preemption of current state law. Federal preemption should be used only selectively and narrowly.

The elements outlined below supplement this proposal. They address three areas: (i) the delay associated with malpractice litigation, (ii) the increasingly common practice of engaging in unnecessary defensive medicine, and (iii) the effects of our antitrust laws on costs and the quality of care activities.

Medical Malpractice Reforms

The costs associated with malpractice litigation have contributed to the rapid growth of health care spending. These costs include the direct costs of insurance, litigation, and settlements. Perhaps most importantly, however, our malpractice system creates incentives for physicians to engage in defensive medicine—excessive tests, failure to delegate certain tasks to other qualified professionals, and in general a more elaborate style of care than is necessary for the provision of sound medical care.

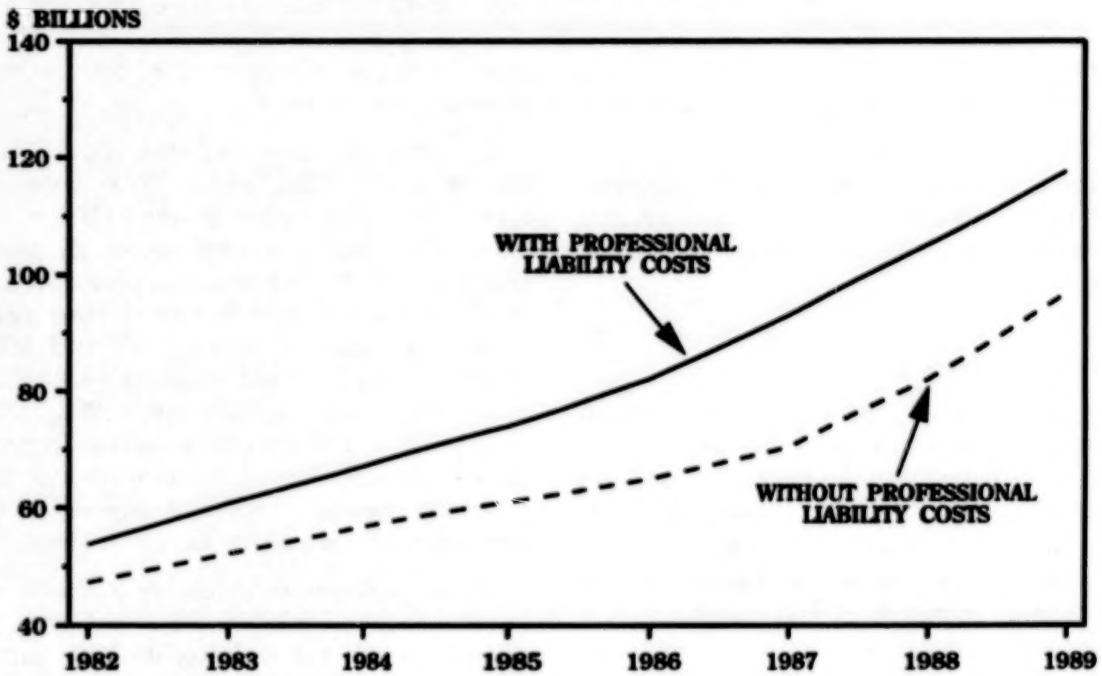
In 1989, defensive medicine accounted for an estimated $20.7 billion, 17.6 percent of total physician expenditures (Moser and Musacchio, 1991). In addition, of all medical practice growth components, professional liability premiums exhibited the fastest annual percentage growth between 1982 and 1989—increasing 15.1 percent annually (AMA Socioeconomic Monitoring System, 1982; 1989). Charts 17 and 18 present increases in professional liability premiums relative to other physician practice costs and impact on total physician service expenditures over time.

Often, unnecessary defensive medicine may result from a misperception on the part of providers of the real potential for liability. A recent study found that physicians in New York State tend to overestimate the risk of being sued by a factor of three (Harvard Medical Practice Study, 1990). For that reason, efforts should be made to communicate the true level of liability risk to providers.

Not all unnecessary defensive medicine is attributable to fear of liability. In some cases, as in fee-for-service medicine, health care providers may have a strong economic incentive to engage in such activity. The fear of liability, however, does result in an increase in the degree and kind of diagnostic testing, the reluctance to delegate certain basic functions, and the abandonment of care for some high risk patients or in high risk areas of treatment such as obstetrics. Based on a 1984 study, 41.8 percent of physicians made at least one change in their practice patterns in response to risk of malpractice liability. The average physician increased record keeping costs by 2.9 percent, prescribed 3.2 percent more tests and treatment procedures, increased follow-up visits by 2.6 percent, and spent 2.4 percent more time with patients (Reynolds et al., 1987).

In addition to the monetary costs associated with medical malpractice litigation, there are

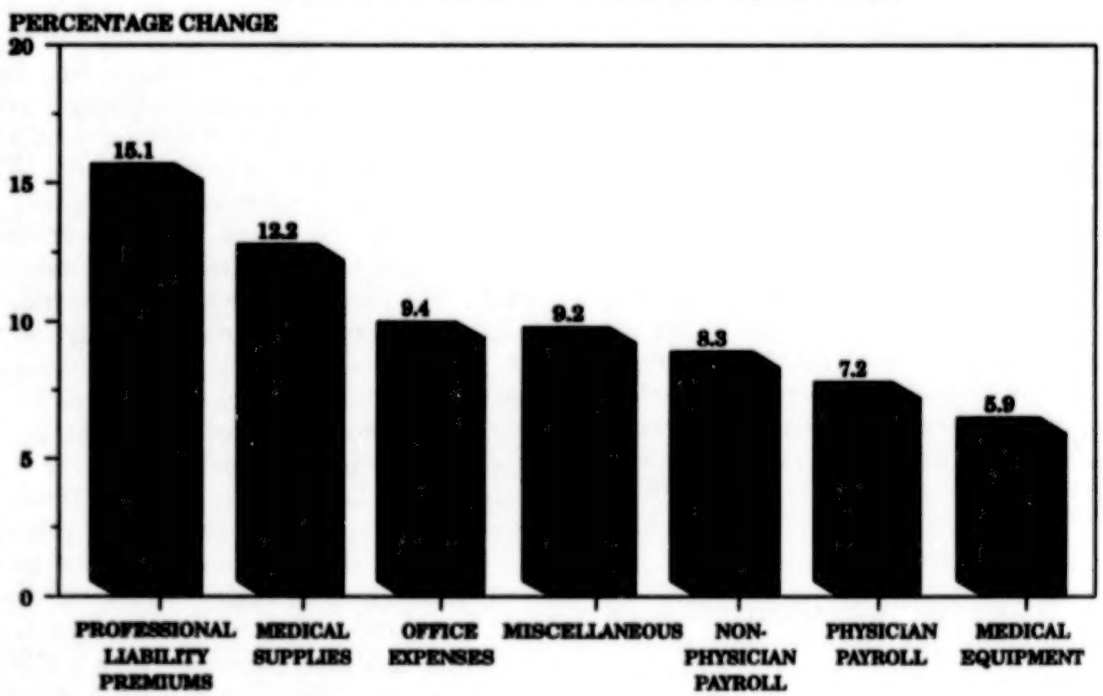
Chart 17. PROFESSIONAL LIABILITY COSTS AS A PORTION OF TOTAL PHYSICIAN SERVICE EXPENDITURES



SOURCE: Expenditures including professional liability costs, HCFA; expenditures excluding professional liability costs, AMA

Chart 18. GROWTH IN MEDICAL PRACTICE COST COMPONENTS

(AVERAGE ANNUAL PERCENTAGE CHANGE, 1982 TO 1989)



SOURCE: AMA Socioeconomic Monitoring System, 1983 and 1989 core surveys

other costs that cannot be quantified. Both providers and patients suffer from the protracted process of litigation. Patients who ultimately gain a recovery must wait years to recover the damages due them. Physicians are often as troubled by the process of litigation as its results.

Collectively, these monetary and emotional costs erode one of the most important aspects of health care, the doctor—patient relationship. What should be a cooperative relationship marked by trust between the doctor and patient is sometimes wary and somewhat adversarial. Reduced communication may undercut the patient's confidence in the physician and breed passivity in a patient, leading to a decrease in patient information about treatment.

Reform of the medical malpractice system offers the prospect of not only reducing monetary costs but, as importantly, helping to restore patient confidence in the medical system and provider confidence in our legal system.

Beyond the provisions in the Health Care Liability Reform and Quality of Care Improvement Act the Administration endorses the following approaches to reduce the delay of malpractice dispute resolution, reduce the amount of unnecessary defensive medicine, and clarify the application of antitrust laws in the provision of health care:

Alternative Dispute Resolution (ADR).— The desire of physicians to avoid malpractice litigation extends beyond the issue of liability and the perception that outcomes are unpredictable. Removing malpractice suits from the adversarial forum of the courtroom offers at least three benefits. It will lessen the sense of confrontation of the dispute. In many, if not most, cases it will speed resolution of the dispute. And, it will vest resolution of often complex medical issues in a person or persons who will likely have more experience with medical issues than the typical member of a jury.

The Administration supports two approaches to persuade or require parties to use ADR and seeks to work with Congress to consider two other approaches that would remove the dispute from a traditional trial setting altogether.

Encouraging the Use of ADR Through Party Choice. The Administration supports amending state and Federal rules of civil procedure to permit either party to litigation to make an offer to use ADR. If the party refusing to engage in ADR loses at trial, that party must pay the others attorney's fees. This change in the rules will provide a strong incentive for parties to consider seriously the desire of the other party to resolve the dispute without the necessity of a full trial.

State Contract Law. The Administration seeks to encourage agreements between patients and providers, made prior to the delivery of health care services, to use out-of-court dispute resolution mechanisms if a dispute arises. It is unclear, however, whether such contracts are valid in all states. The President's plan proposes to permit contracts between patients and providers that require non-binding arbitration before a lawsuit can be filed notwithstanding conflicting state law.

Promising Areas for Innovation. Although the proposals discussed below address the issue of delay and the merit of increasing the expertise of those who decide malpractice cases, each has its shortcomings and critics. The Administration believes, however, that it is important that these issues become an integral part of the debate on reforming our malpractice system. The Administration will cooperate with Congress, state legislatures, medical associations, and others to explore whether such proposals can remedy the problems of the current system.

- *Mandatory ADR for Federal Beneficiaries.* Several malpractice reform proposals would make the receipt of Federal health care benefits implied consent to enter into ADR if a dispute arises out of the health care provided. The added cost of health care resulting from the shortcomings of our malpractice litigation system is directly reflected in the cost of these programs to the treasury. The Federal government thus has a legitimate interest in finding ways, such as ADR, to reduce those costs.

- *Mandatory ADR for All Claimants.* To avoid the judgment of lay juries and the delay inherent in our current civil justice system, some have called for taking medical malpractice cases out of the courts entirely. The American Medical Association, for example, has proposed that every state create an administrative tribunal to hear medical malpractice claims with courts permitted only appellate review. Although the theoretical benefits of such a system are obvious, serious questions of constitutionality, practicality, and increasing bureaucracy must be resolved before any large-scale proposal moves forward.

Offers of Settlement.—The Administration also proposes to permit either party to a malpractice action to make a formal offer of settlement. This provision has been discussed for application in other areas of civil justice in need of reform, such as product liability. In effect, the provision makes Rule 68 of the Rules of Civil Procedure available to plaintiffs as well as defendants.

Standards of Care.—Medical associations, authors, and commentators have attempted to provide guidance to physicians on appropriate standards of medical care. It is the tort system, however, through the judgments of lay juries, that too often defines the standards of care physicians must meet. The precedential value of the jury's determination and the uncertainty generated in gray areas, can effect profoundly provider behavior.

Variation is inherent in case-by-case determinations by different juries. This translates into a perceived lack of predictability in our medical malpractice litigation system. This uncertainty and the role of lay persons in determining what is adequate medical care has encouraged overly cautious behavior and some resentment of the litigation system in the medical community.

In recent years, there has been increased interest in the development of guidelines or standards of care as references for physicians by medical groups, insurers, and legislators. The debate has centered on who would develop such standards, the degree of specificity required to make the standards useful, the degree of flexibility necessary to reflect the individuality of patients and circumstances, and what use and legal force, if any, should be given to such guidelines or standards.

The Omnibus Budget Reconciliation Act of 1989, Public Law 101–239, established the Agency for Health Care Policy and Research within the Public Health Service to promulgate guidelines and standards of quality and other "performance measures." No provision was made for giving any legal effect to such standards in litigation, however.

The Secretary of Health and Human Services will intensify his efforts to develop these guidelines and standards. The Secretary will also consult with experts in the field, including providers, medical associations, legal scholars and others, to study the feasibility and desirability of giving some legal force to such guidelines. The Secretary's study should include a discussion of the process for forming such guidelines or standards, and the degree to which the guidelines would have to be specific and/or take into account variations in practice geographically, because of resources, or the age and condition of the patient.

The Administration believes that practice guidelines and standards offer great promise in reducing the level of unnecessary defensive medicine without compromising the quality of medical care. Physicians knowledgeable about the practice guidelines and standards can look to them in determining the adequacy of care provided to their patients.

Guidelines and standards of care could offer the added benefit of enhancing the value of alternative dispute mechanisms. As alternative dispute resolution is increasingly used, practice guidelines and standards of care will heighten confidence that the mediator or arbitrator will reflect accurately the behavior of a jury if the case proceeds to trial. Thus, parties will be better positioned to judge the consequences of rejecting the proposed determination.

Antitrust Law

In addition to the issues of medical liability and dispute resolution, antitrust issues bring law and medicine together. For instance, professional peer review has always reflected

a tension between the necessity to weed out those who do not meet the standards of the profession and the possibility that such review could be used unfairly and illegally to limit competition in the profession. With the emergence of new methods of health care delivery, like HMOs and PPOs, and increasingly sophisticated and costly technology, confusion about the proper application of the antitrust laws in the health care field has grown.

The Administration proposes a series of steps to assure that the new emphasis on quality of care is not undermined by concerns of unwarranted allegations of collusion, that concerns of antitrust liability do not chill the evolution of a more organized and efficient health care delivery system, and that the cost of health care is not raised unnecessarily because of duplication of costly technology and services.

The President's initiative includes legislation to address the issue of the unnecessary duplication of technology and the provision of guidance by the Federal government on the issue of the application of the Federal antitrust laws to peer review and managed care issues.

Medical Technology.—Much of the increased cost of health care has resulted from the high costs associated with advanced technology. Often expensive equipment is duplicated by competing health care organizations because of concern over the application of the antitrust laws to the sharing of equipment and services. As a result, the acquisition of expensive technology may far exceed what is needed. To reduce the costs of high technology equipment and services, the Administration will again urge Congress to pass the joint production venture legislation, S. 1163, transmitted by the Departments of Justice and Commerce on April 29, 1991.

Peer Review Activities.—State disciplinary boards and hospital medical staffs often review physicians qualifications to determine whether a license or hospital privileges for the physician should be limited, denied, or revoked. Presumably, the goal is to ensure an appropriate level of quality of care. Often, however, the physician whose privileges are curtailed will sue the reviewing physicians and witnesses on the grounds that the review is really a veiled attempt to limit competition.

Some commentators suggest that the creation of certain safe harbors for actions limiting physician privileges can avoid litigation costs and the chilling effect of potential litigation without unduly limiting competition. The Administration does not believe changes in substantive law are necessary. Rather, the Department of Justice will provide enhanced guidance for state peer review boards and hospitals with respect to actions to deny, revoke, or suspend the license of privileges of any physician.

PPOs, HMOs and Other Pooling Arrangements of Providers.—The emergence of managed care is creating new issues in health care. For instance, if physicians in an area band together to form a PPO, thus fostering price reductions and managed care, it may be alleged that they are nonetheless reducing the number of competitors for physician services in the marketplace. At the same time, diligent enforcement of the antitrust laws is necessary to prevent price fixing and illegal tie-ins in the provision of health care. Reducing the fear of liability for certain beneficial activities while maintaining the deterrent effect of the antitrust laws for traditional anticompetitive endeavors is the challenge for antitrust enforcement agencies, particularly the Department of Justice and the Federal Trade Commission.

The Administration will clarify the antitrust standards that apply to provider pooling arrangements such as PPOs and HMOs. Additionally, the Department of Justice will increase its enforcement efforts against those in the health care industry who boycott such provider organizations. Together with the efforts of the Federal Trade Commission, the actions of the Department should provide the guidance that these evolving entities need to prosper.

F. Reducing Administrative and Paperwork Costs

Overview

Recent studies suggest that paperwork savings of $67 to $100 billion a year would be possible if the United States shifted to a Canadian-style national health insurance program (GAO, 1991; Woolhandler and Himmelstein, 1991). A critical review of available information by OMB indicates that potential savings are much lower, at most $31 to $49 billion (Director Darman, October 1991, Testimony, House Ways and Means Committee). Other analyses have concluded that any administrative savings under a nationalized health plan would be more than offset by an increase in benefit costs. One analysis estimated total savings in administrative costs in the United States under a Canadian-style system would be $47 billion; however, these administrative efficiencies of a common benefit package would be less than the $78 billion increase in benefit costs that would come with the common package (Sheils and Young, 1991).

Moreover, simple administrative cost comparisons are misleading because they fail to capture the value added by effective administrative measures. The United States spends between $2 billion and $4 billion a year on various quality assurance programs, measures that improve health care and reduce costly and potentially dangerous inappropriate care. And, as a recent study points out, delays in treatment under the Canadian system lead to "hidden" costs of up to 0.6 percent of GDP—or more than $34 billion dollars a year if translated to the United States (Danzon, 1991).

Nonetheless, significant administrative savings are possible while maintaining choice and diversity for our citizens. Moreover, paperwork burdens, hassles, and confusion associated with obtaining health care can be reduced. The reform proposal contains five initiatives to accomplish these goals:

- Electronic billing using standardized formats will dramatically reduce paperwork and reduce administrative costs.
- Shifting from costly case-by-case medical review to pattern of care review will reduce the "hassle" factor for physicians, focus review efforts on problem areas, and improve quality.
- Use of electronic cards for billing and eligibility determinations will reduce paperwork and confusion for consumers at the point of service.
- Development of computerized medical record systems will reduce paperwork burdens for providers while improving quality.
- Market reforms will reduce administrative costs in the small group market by up to $9 billion a year by providing efficiencies of scale through group purchasing for small businesses (HINs) and by eliminating medical underwriting costs.

These reforms will bring the administration, billing, and record-keeping in our health care system into the twenty-first century, through a system-wide movement to automation and more standardized billing, claims adjudication, eligibility determination, and clinical information. The effective implementation of market pooling mechanisms will consolidate consumers into more streamlined, better managed groups that have more leverage in the health market.

Background

Health care overhead is a diverse category that embraces a wide range of activities including: claims processing costs for insurers, billing costs for providers, utilization review, quality assurance, maintenance of enrollment and eligibility records, premium collection, marketing costs, and profit. Public and private insurance and billing costs totalled almost $80 billion in 1991, or about 12.2 percent of total personal health spending. Insurance administration accounts for $43.6 while provider billing costs account for the remaining $36.2 billion.

Of the total of $43.6 billion for insurance administration in 1991, $32.8 billion is for private insurance, $5.7 in federal costs, and $5.0 billion in State and local costs. The bulk of this spending (77.5 percent) is for

Table 5–7. Insurance Administration and Provider Billing Costs in the U.S., 1991

(Source: HCFA, OMB staff estimates)

	Cost in Billions of Dollars	As Percent of Total Administration	As Percent of Total Personal Health Spending
Insurance Administration	$43.6	54.6%	6.7%
Hospital Billing Costs	$17.1	21.5%	2.6%
Physician Billing Costs	$10.4	13.0%	1.6%
Billing Costs for Other Providers	$8.7	10.9%	1.3%
Total Insurance and Billing Costs	$79.8	100.0%	12.2%

claims processing, quality assurance, and general administration. Marketing costs and profits total $6.0 billion while taxes paid by private insurers account for the remaining $3.7 billion.

Insurance administration costs have increased from 5.3 percent of total personal health spending in 1965 to 6.7 percent in 1991. This change primarily reflects an increase in insurance coverage during the interval. Out-of-pocket spending, as a percent of total personal health spending, decreased from 55.9 percent in 1960 to 23.3 percent in 1990 (Levit et al, 1991). With this decrease, administrative costs were bound to increase.

Private insurance administrative costs vary substantially with firm size as a percentage of benefit payments, ranging from up to 40 percent of benefit costs for very small firms to under 6 percent for very large firms. This disparity in costs reflects the fact that large businesses enjoy efficiencies of scale in the purchase and administration of insurance benefits. Risk premiums are lower for large groups coverage because benefit costs are much more predictable. Commissions for brokers also are higher for very small firms due to the retail nature of this segment of the market.

Proposal

Administrative costs could be cut by as much as 25 percent under five major reform initiatives. Four of the initiatives would streamline paperwork. The first four of these

Table 5–8. Administrative Costs for Public and Private Insurance in the U.S., 1991

(Source: HCFA, HIAA, BCBS, OMB staff estimates; excludes billing costs for providers)

	Cost in Billions of Dollars	As Percent of Total Administration	As Percent of Total Personal Health Spending
Total Public and Private Insurance Administrative Cost	43.6	100.0%	6.7%
Claims Processing, Quality Assurance and General Administration (private and public)	33.8	77.5%	5.2%
Taxes Paid by Private Insurers	3.8	8.6%	0.6%
Marketing and Commissions	3.8	8.8%	0.6%
Profit	2.2	5.1%	0.3%

Table 5–9. Health Insurance Overhead Cost as Percent of Benefit Payments

(Source: CRS, 1989)

Firm Size	Claims Administration	General Administration	Interest Credit	Risk and Profit	Commissions	Premium Taxes	Total
1 to 4	9.3	12.5	-1.5	8.5	8.4	2.8	40
5 to 9	8.6	11.2	-1.5	8.0	6.0	2.7	35
10 to 19	7.2	9.2	-1.5	7.5	5.0	2.6	30
20 to 49	6.3	7.6	-1.5	6.8	3.3	2.5	25
50 to 99	4.3	4.8	-1.5	6.0	2.0	2.4	18
100 to 499	4.1	4.0	-1.5	5.5	1.6	2.3	16
500 to 2,499	3.9	3.2	-1.5	3.5	0.7	2.2	12
2,500 to 9,999	3.8	1.4	-1.5	1.8	0.3	2.2	8
10,000 or more	3.0	0.7	-1.5	1.1	0.1	2.1	5.5

initiatives are already underway under the leadership of Secretary Louis Sullivan of the Department of Health and Human Services. These four paperwork reduction initiatives could reduce administrative costs by as much as 8 percent, saving up to $4 billion a year. These initiatives would be complemented by reform of the small group market. As described more fully in Chapter 3, health insurance market reform could reduce administrative costs for small group coverage by as much as 40 percent, saving up to $9 billion a year.

Reducing Claims Processing and Billing Costs Through Standardization and Automation.—Paper claims are expensive. Estimates suggest that providers and insurers save up to $2 per claim through electronic billing, and more is saved when claims are reviewed electronically. Since over three billion claims are submitted on paper every year, substantial savings are possible just by increasing electronic submission rates.

Standardization of claims forms can reduce billing costs and reduce provider billing costs to levels comparable to those that might be achieved under single payer systems. In December, 1990, the Health Care Financing Administration's HCFA-1500 claims form was finalized. This form—which is used for physician and outpatient services—was developed by the Uniform Claim Form Task Force, co-chaired by the American Medical Association and HCFA. Task Force participants included representatives of every major third-party payer. While use of the HCFA-1500 is voluntary, wide acceptance is expected. Similar efforts have led to near universal acceptance of the UB-82, as the standard form for inpatient hospital bills.

At Secretary Sullivan's recent Forum on Administrative Costs, Blue Cross/Blue Shield of America and the Travelers Insurance Company agreed to head up a public/private group to increase electronic claims and to standardize data elements and electronic transmission rules. The group is meeting already. Its recommendations are expected soon.

HCFA is actively working with the private sector to develop technical standards to promote greater use of electronic billing. Currently, 75 percent of Medicare Part A and 42 percent of Part B claims are submitted electronically. Electronic billing also reduces costs for providers and helps reduce clerical errors. Comparable savings can be achieved for private sector claims. HCFA has set 100 percent electronic submission for hospitals and 75 percent for others within three years—the private sector must drive toward similar efficiencies.

The combination of electronic claims submission and standardization of the data elements required for claims will reduce provider cost and frustration. Providers submitting claims

electronically benefit from faster and clearer resolution of claims. Moreover, electronic systems will help avoid technical mistakes, such as missing one line on a form, that often delay payment.

Streamlining Medical Review.—A third area—improving medical review—can reduce the "hassle factor" for physicians while reducing costs for unnecessary care. The goal would be to shift away from claim-by-claim denials toward monitoring and encouragement of cost-effective practice patterns. Claim-by-claim review is burdensome and costly—sometimes the cost of the review can exceed the potential savings.

HCFA has developed and is now testing the Uniform Clinical Data Set (UCDS) a new system that would permit a shift to pattern review for inpatient hospital care. The UCDS is a state-of-the-art system for abstracting critical medical information for hospital records. Once this information is abstracted and entered into a computerized system, "expert" system programs can identify patterns of care that suggest a systematic problem that might warrant further targeted review and corrective action.

If the UCDS system proves to be successful in practice, it would serve as a model for use by private insurers. In a complementary effort, the Public Health Service is devoting $130 million in 1991–1992 to outcomes research to increase information about what patterns of care are most effective in improving health outcomes and at what cost.

Developing Electronic Cards.—Secretary Sullivan has launched an initiative to accelerate development of electronic cards for use by consumers.

Electronic cards would be used by patients at the point of service to provide comprehensive insurance information to providers. This would eliminate the need for patients to repeatedly fill out confusing forms. Such cards also would streamline billing procedures for doctors and hospitals by providing immediate information regarding eligibility, coverage, benefits, copayments and deductibles.

Dollar savings will accrue directly to insurers and providers through more efficient administrative procedures, and be passed on to consumers through lower premiums and out of pocket costs. Eventually, electronic cards could be used for storage of the card holder's medical records. This would help prevent duplication of tests, medication errors, and other quality of care problems.

Developing Computerized Medical Record Systems.—Secretary Sullivan also has initiated a task force to accelerate development of computerized medical record systems.

Computerization will facilitate rapid access to critical information regarding an individual's past medical record. Once computerized patient records and related information networks are in widespread use, providers will have access to state-of-the-art information on the effectiveness of various care paths as well as more complete, accurate patient medical records.

"Expert" systems can be built-in as part of these systems to alert physicians to potential problems, such as the need to follow-up on an abnormal test result. Computerized records will also strengthen quality assurance by providing hospitals and health plans with reliable statistical information regarding outcomes and complication rates.

Health costs could be reduced as well. Up to 20 percent of all medical care performed in the United States may be unnecessary or harmful. Computerized patient records will capture clinical data for effectiveness research. This research will help physicians better understand when certain costly therapies should be used.

Early reports are encouraging. The General Accounting Office has reported that an automated medical record system reduced hospital costs by $600 per patient in a Veterans Affairs hospital. Other studies have demonstrated reduced lengths of stay associated with computerized patient records. If broadly implemented, computerized patient records could reduce unnecessary care by about 5 to 10 percent, saving $20 billion a year by the end of the decade. More significant savings are likely in later years.

Reducing Overhead Costs Through Health Insurance Market Reform.—Finally, health insurance market reform will reduce administrative costs for small group coverage

by an average of 40 percent. Savings will be even higher for groups with 10 or fewer workers. The bulk of this savings will be achieved through health insurance networks (HINs)—group purchasing associations for small business and individual coverage. It is projected that 67 percent of coverage sold to firms with fewer than 100 workers will be provided through HINs.

Even outside of HINs, substantial savings will be achieved through elimination of costs associated with medical underwriting. Moreover, by refocusing competition on costs, the reforms will also help to reduce marketing costs.

G. Making Public Programs More Efficient

Government health care programs at all levels account for 44 percent of national spending on personal health services. Costs for these programs have been increasing even more rapidly than for the population as a whole. Accordingly, no comprehensive health system reform proposal can be complete without measures to help make these programs more efficient. Indeed, thoughtful reform now is needed to prevent future problems that could threaten these programs.

1. Reforming the Medicaid Program By Enhancing State Flexibility

Overview

The President's reform proposal would dramatically modernize the twenty-six year old Medicaid program and provide States with significant new flexibility for reform.

- *Medicaid recipients will benefit from enhanced access and improved quality through coordinated care plans.*
- *States will have new flexibility to take advantage of innovation, program efficiencies, and better methods for cost control.* As Medicaid costs have risen by over 23 percent a year since 1989 (from $61.2 billion to $92.1 billion in 1991), States have strained to keep up. Thus, the federal and State governments must be partners in cost containment and reform.
- *Enhanced State flexibility and greater use of coordinated care can reduce Medicaid cost growth from a projected 16 percent a year and result in significant savings that can help fund expanded insurance coverage for an additional 24 million low and modest income Americans through the new transferable health insurance credit system (see Chapter 4).*
- *Coverage of all non-Medicaid poor for basic services will be fully financed by the Federal Government.* States would be able to retain their share of savings from Medicaid program reform. Federal savings would revert to State residents to provide health insurance for the non-Medicaid poor, without any State match.

Medicaid currently provides health insurance benefits for 26 million low-income Americans. Recently, Medicaid also has become the primary vehicle for funding "uncompensated care" provided by disproportionate share hospitals (DSH)—hospitals that have high charity care case loads ($12 billion in federal payments matched by the States—in 1993). These DSH payments would not be affected by this proposal.

Medicaid has been widely criticized as providing fragmented, episodic, and often substandard care. Moreover the program is viewed as wasteful and inefficient. These problems stem primarily from continued reliance on an outdated fee-for-service delivery system. In addition, the program is overly rigid and bureaucratic.

Under the proposal, Medicaid would be restructured to rely primarily on delivery of health care through coordinated care systems. Moreover, States would have new flexibility to respond to local needs and concerns. States would have the option of choosing between two broad approaches.

- A State could maintain existing Medicaid eligibility and benefit levels while shifting enrollment into coordinated care pro-

grams. Under this approach, the new transferable tax credit (certificate) system would operate separately from the existing Medicaid program, though States would play an important role in qualifying individuals for the tax credit.

- Alternatively, a State could combine its existing Medicaid programs with the new health insurance credit system to develop a new universal access program covering all State residents with incomes below poverty. Under this approach, a State could operate a single public insurance program or could provide credits for purchase of private coverage.

Coincident with these reforms, federal funding for acute care for the non-elderly (excluding DSH payments) would shift to a new per capita payment to the States. This would provide States with new incentives to maximize program efficiencies through coordinated care and other measures. Overall, the reforms would improve quality and access for program recipients while greater efficiency would free up funds to expand access for other low income individuals and families through the new tax credit system.

Background

Medicaid currently is a joint federal/State program designed to meet the health insurance needs of certain low-income individuals. States set most program rules within broad federal guidelines, determine beneficiary eligibility, and pay provider claims.

In general, Medicaid eligibility is linked to other cash assistance programs such as Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). In recent years, mandatory eligibility has been extended to certain groups with incomes above the cash welfare program standards (for example, poor and near poor pregnant women and children). Optional coverage extends to certain other groups, such as the "medically needy," whose illnesses force them to "spend-down" to meet Medicaid eligibility criteria.

Current Medicaid eligibility requirements leave many poor without coverage. Certain categories of persons cannot qualify for Medicaid under current rules, no matter how poor or how sick they are (non-disabled single adults and childless couples, for example). Only about 45 percent of the poor are covered by Medicaid. Another 26 percent have other insurance. Twenty-nine percent, therefore, are without insurance.

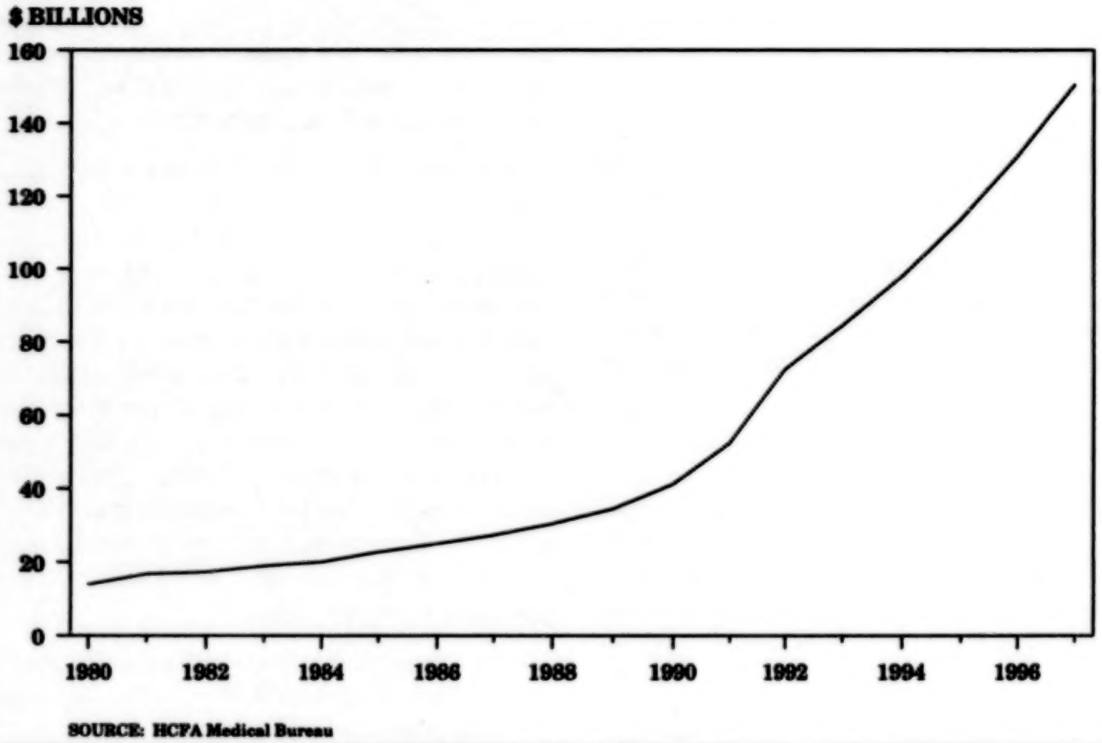
Problems With the Current Program.—Most Medicaid recipients receive health care through traditional and costly fee-for-service arrangements. Physicians, hospitals, and other providers are paid on the basis of itemized bills for the services they render. As a result, strong incentives exist to provide additional services regardless of benefit. Providers are not paid on the basis of outcomes: no one is paid to keep patients in good health. Nor is there anyone responsible for coordinating services to avoid duplication and to improve quality. As a result of this perverse mismatch of incentives and responsibilities:

- The care many Medicaid patients receive is often fragmented—too little, too much, inappropriate, or too late;
- Too many recipients use hospital emergency rooms as their primary entry point to the medical care system, often for non-emergency conditions; and
- Too many people are deterred from seeking treatment in the early stages of a medical condition. Receiving treatment in the later stages often leads to hospitalization and other care that could have been avoided.

The Medicaid program also has been strained due to frequently added service and eligibility mandates, increased caseloads, court mandated payment levels, and overall health care inflation. As a result of these forces, Medicaid is the fastest rising portion of both federal and State budgets.

Program Costs.—In 1993, combined federal/State spending on Medicaid will surpass $158 billion, up from $61.2 billion in 1989—a 250 percent increase. The federal contribution, based on State median income ranging from 50 to 83 percent of program expenses, will exceed $84.5 billion in 1993, or a 245 percent increase since 1989 ($34.5 billion).

Chart 19. GROWTH IN FEDERAL MEDICAID COSTS



SOURCE: HCFA Medical Bureau

As Table 5–10 shows, there are three main components to federal Medicaid program costs: (1) acute care for the non-elderly, (2) long-term care and services to "dual eligibles" (those eligible for both Medicare and Medicaid), and (3) program administration.

Coordinated Care.--While the current program is exploding, causing a crisis at the federal and State level, successful experience with coordinated care programs show that responsible reforms can improve the health care available to the disadvantaged while moderating cost growth. Three examples underscore this point:

- A Detroit-based health maintenance organization (HMO), Comprehensive Health Services, provides care for the 60,000 Medicaid recipients and has saved the Medicaid program at least $6.9 million in 1990. These savings are due to a reduction in unnecessary hospitalizations and in-

Table 5–10. Projected Federal Medicaid Costs Under Current Law
(Dollar amounts in billions, Federal Share)

	1992	1993	1994	1995	1996	1997	1993–1997
Total Medicaid	72.5	84.5	98.3	113.8	131.2	150.9	578.7
Percent Increase	—	16.6%	16.3%	15.8%	15.3%	15.0%	15.8%
Acute Care (including DSH)	31.0	36.5	42.9	50.2	58.5	67.9	255.9
Percent Increase	—	17.7%	17.5%	17.0%	16.5%	16.1%	17.0%
DSH Payments (non-add)	8.4	9.8	11.4	13.2	15.2	17.2	75.5
Long-Term Care and Dual-Eligibles	38.9	45.0	52.0	59.8	68.5	78.2	303.7
Administration	2.6	3.0	3.4	3.8	4.2	4.8	19.1

creased attention to preventive care, particularly for high risk pregnant women and infants.

- Under Kentucky's Primary Care Case Management (PCCM) program, each Medicaid recipient has a primary care physician responsible for providing or authorizing all non-emergency care. By emphasizing primary and preventive care through a single physician, cost and quality problems associated with overuse of emergency rooms and duplication of medications or tests have been avoided. As a result, the Kentucky program has reduced infant mortality rates and has achieved savings of $25 million a year, or approximately 10 percent of program costs.
- Until 1982, Arizona was the only State that did not participate in Medicaid. County governments provided acute and long-term care for the poor. In 1982, Arizona established a Medicaid program and obtained a waiver to operate this through the Arizona Health Care Cost Containment System (AHCCCS).

  AHCCCS is unique in that all care is provided through coordinated care arrangements. There is no fee-for-service option. Arizona contracts with participating health care organizations (HCOs) through a bidding/negotiation process. Modest savings have been achieved—estimated by HCFA at 5.7 percent in the fourth year of the program compared to fee-for-service alternatives.

While programs of this type hold promise, less than 3 million Medicaid recipients receive care through coordinated care programs: 1.4 million receive care through HMOs and other prepaid health plans, while an additional 1 million receive care through PCCM programs. The remaining 23 million (89 percent) continue to receive care through fee-for-service systems. In contrast, 27 percent of workers and dependents with employment-based private insurance are covered through coordinated care plans, and this percentage continues to grow rapidly (see Chart 15, Chapter 5, section B).

The comparatively small share of Medicaid recipients covered under coordinated care plans reflects a number of factors. Most importantly, under current law, States must go through a waiver process to secure federal approval to establish coordinated care programs. Complex statutory waiver requirements are overly rigid and have blocked a number of initiatives that long have been underway in the private sector. Moreover, State Medicaid programs are subject to political resistance from entrenched interests, a factor that is not significant in the private sector.

It is important to note that Medicaid also has become a vehicle for funding "uncompensated" or "charity" care provided by hospitals to individuals without Medicaid or other insurance coverage. Under recently enacted legislation, States will be able to provide higher Medicaid payments to "disproportionate share hospitals" (DSH) that provide care to a disproportionate number of uninsured patients. Over the next five years, the Federal Government will provide $75.5 billion in DSH payments.

While this is a reasonable stop-gap approach, it has two disadvantages when compared with a direct expansion of insurance coverage. First, there is no assurance that DSH payments are used exclusively for patient care. More importantly, DSH payments for inpatient hospital care fails to provide access to ambulatory care and primary and preventive services that could avert the need for a disabling illness and costly hospital care.

Proposal

The President's proposal focuses reform on the acute care portion of Medicaid for the non-elderly. Long-term care and acute care programs under Medicaid for seniors, including Medicare/Medicaid dual eligibles and qualified Medicare beneficiaries, would remain unchanged. Disproportionate share hospital (DSH) payments under Medicaid also would remain unchanged.

Federal financial participation for acute care (excluding DSH) would be shifted from open-ended cost-based reimbursement to a prospectively determined per capita payment. This change would provide important incentives for program efficiency. The resulting savings reflect the potential for significant improvements in efficiency through either

of the two major reform options that the States would have under the proposal.

The per capita payment would be State-specific, based on total per capita costs for the acute care portion of Medicaid in a State in 1992. Acute care costs related to Medicare recipients would be excluded from this calculation as would DSH payments. The State's 1992 per capita cost would then be indexed for general inflation, using the percent increase in the consumer price index for urban areas (CPI–U) plus an additional amount for medical cost inflation.

From 1960 to 1990, per capita health care costs for the entire United States population increased by about 4 percent a year faster than the CPI–U. Thus, an add-on of 2 to 4 percent in addition to the CPI–U for 1997 and future years seems reasonable. Savings of this magnitude should be possible through coordinated care and increased flexibility for State programs. A phase-in would provide time for States to take advantage of the new programmatic flexibility provided.

Actual federal payments to a State would equal the product of the total number of Medicaid recipients in the State times the inflation indexed State per capita acute care costs times the Federal Matching Assistance Percentage (FMAP). The FMAP formula would remain unchanged from current law and is intended to reflect a State's relative need for federal assistance. (The federal matching assistance percentage (FMAP) = 100 - .45 × [(State per capital income)/(U.S. per capita income)]^2.) Different per capita payment amounts could be used for different age-sex or other groupings to adjust for changes in the population covered by a State program over the years.

Although the proposal does not affect DSH payments, the need for DSH payments would decrease dramatically. With a projected increase in insurance coverage of 29 million Americans resulting from tax credits and other reforms, fewer uninsured patients would burden hospitals with "charity" care costs. Thus, additional funds could be available to further expand the credits. At State request, the payment formula could be revised to include DSH payments within the federal per capita payment while still yielding the same aggregate savings as those proposed.

State Option 1.—Separate Medicaid and Tax Credit Programs.—As noted above, States would have two broad options regarding reform of their Medicaid programs for acute care services provided to the non-elderly. Under the first option, States would shift all non-elderly Medicaid recipients into coordinated care programs, over a five year period. Otherwise, program rules would remain substantially unchanged.

Coordinated care programs would include health maintenance organizations (HMOs), preferred provider organizations (PPOs), primary care case manager (PCCM) programs and other cost effective alternative delivery systems. Current restrictions that impede access to coordinated care plans under Medicaid would be relaxed. Because enrollment would be shifted to coordinated care, State waivers to continue significant fee-for-service enrollment would be necessary.

Eligibility rules would remain the same as under the current Medicaid program. States would be required to continue to cover all current mandatory eligibility groups under Medicaid, as well as any optional groups they covered as of January 1, 1992.

States would continue to provide mandatory Medicaid benefits. States that currently provide optional Medicaid benefits would be able to adjust these benefits, but would be required to maintain the actuarial value of the total benefit package (e.g., an optional benefit could be dropped if another benefit of equivalent value is added). States also could modify the amount, duration, and scope of mandatory or optional benefits subject to a requirement that the actuarial value of the benefits be maintained. As under current law, providers would be required to accept Medicaid rates as payment-in-full with no significant cost sharing or balance billing.

Under this option, States would be responsible for coordinating certain aspects of the health insurance credit program. The tax credit would be used for the purchase of private insurance coverage. States would certify eligibility for and the amount of the

health insurance credit for those who wish to obtain their tax credit prospectively.

States also would be required to define a "basic" benefit package with an actuarial value equal to the tax credit amount. And, if a sufficient number of insurers do not offer the basic plan, States would be required to assure that at least two private health plans offer this basic plan to credit recipients within the State. Federal/State quality assurance programs would continue to assure proper program administration, e.g, proper eligibility determination for Medicaid and tax credit recipients and prevention of fraud and abuse.

State Option 2—Unified Program.—Under this option, States could establish a unified program that combines Medicaid with the new federal health insurance credit to provide health insurance coverage for all State residents with incomes below poverty. Coverage would be phased-in in tandem with the phase-in for the health insurance credit.

States would have broad flexibility in establishing these programs. They could operate a unified public insurance program or establish a State health credit program to supplement federal health insurance credit payments. Any eligible individual or family could opt-out of the State's public insurance program to purchase private insurance. Those who opt out would receive the full amount of the federal health insurance credit that they would otherwise be eligible to receive. The credit could be higher if the State supplemented the health credit.

States that provide insurance directly would cover all Medicaid mandatory benefits and as well as prescription drugs. States would have flexibility to modify the amount, scope, and duration of benefits and could add or drop optional benefits provided that the actuarial value of the benefit package is maintained when spread over all individuals who are eligible to participate in the program.

States that operate a unified health insurance credit program would be subject to a maintenance of effort requirement. The State's financial contribution would be set to equal the amount the State would have paid had it maintained a separate Medicaid program, as under option 1.

To help finance these programs, States would receive a lump sum payment from the Federal Government. This payment would equal the sum of federal per capita payments for those who meet Medicaid eligibility requirements and health insurance credit payments for those who are eligible for them. Payments would be based on estimates of the Medicaid and health insurance credit eligible populations within the State. Estimates would be base year eligibility rates updated to reflect changes in population and changes in unemployment and other factors likely to influence the size of the eligible population. Adjustments would be made to reflect actual participation.

To the extent practical, States would no longer apply complex Medicaid eligibility standards. Eligibility would be based simply on individual or family income in relation to poverty. States would help to administer the federal health insurance credit and would assure availability of "basic" benefit coverage from at least two private health plans, as under option 1.

2. Phasing-Out Duplicate Subsidies and Increasing Efficiency in Other Federal Health Programs

Medicare Program History

Since enactment in 1965, Medicare has successfully reduced the financial burden of health costs for the nation's elderly. However, the Medicare program also has experienced unsustainable increases in costs that have far outpaced both initial projections, and inflation (far exceeding the CPI), and even the medical component of the CPI.

Medicare outlays were $3.4 billion in 1967, and at the time, projected 1990 outlays were $15.7 billion. Actual 1990 Medicare outlays totalled $110 billion. The average annual rate of growth in Medicare expenditures between 1970 and 1990 was over 14.7 percent, well above the rate of inflation and beneficiary increases (about 8.2 percent). The following table compares actual Medicare

growth rates to inflation and beneficiary growth.

Medicare has outpaced the Medical-Consumer Price Index (MCPI) and the Consumer Price Index-Urban (CPI–U) by an average annual rate of 6.3 percent and 8.4 percent, respectively, over the 1970–1990 period. Over the next five years, if not reformed, it will continue to surpass general inflation rates, as indicated in the graph and chart below.

With almost 12 percent a year growth anticipated for each of the next five years, reasonable efficiencies must be found in Medicare growth to avoid draining American taxpayer resources—regardless of the beneficial private sector effects of the President's plan's private market reforms.

Reforms will not affect benefits for seniors.—Because important efficiencies are possible in the Medicare program, no senior will have any benefits reduced as part of health care reform. In fact, senior citizens could save money as a result of possible Medicare reforms—due to the lower coinsurance payments and lower Part B premiums that automatically

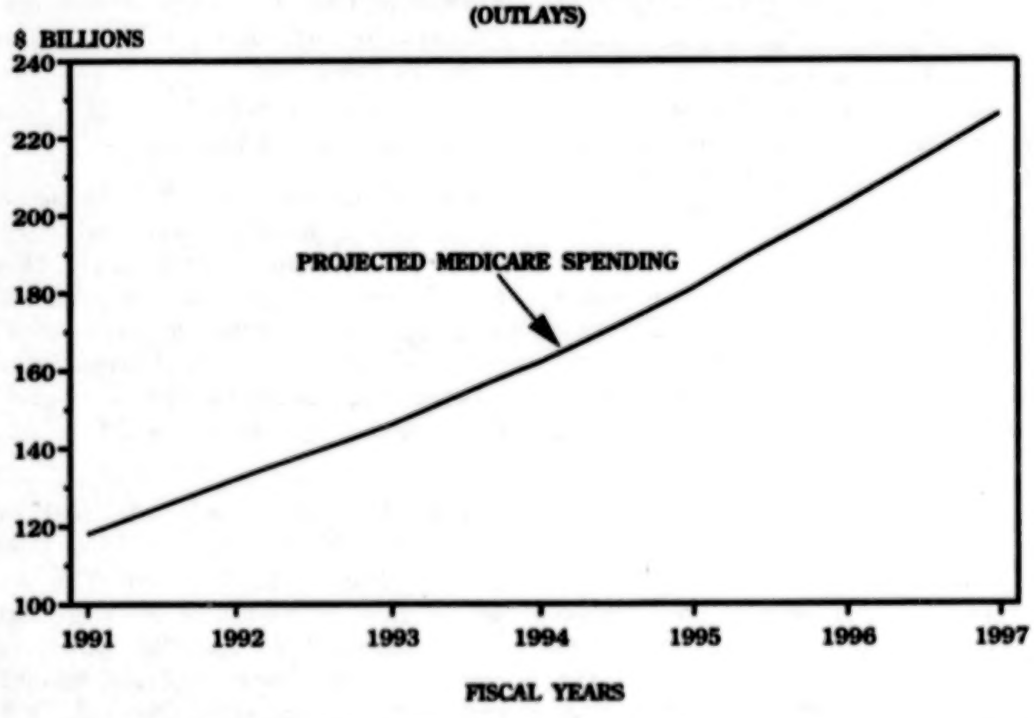
Table 5–11. Average Annual Medicare Growth Compared to CPI–U and Beneficiary Growth, 1970 through 1990

	Annual Growth Rate	Excess over CPI–U and Beneficiary Growth
CPI–U + Beneficiary Growth	8.2%	—
Medicare	14.7%	+80%

Chart 20. GROWTH IN FEDERAL MEDICARE COSTS

AVERAGE ANNUAL INCREASE – 11.5%

(OUTLAYS)



result from many supplemental medical insurance (SMI) reforms.

Hospital Insurance (HI) Reforms

Under current law, the Medicare Hospital Insurance program will grow at 10.6 percent per year from 1993 to 1997. Numerous policy changes exist to reduce this high annual rate of growth—without affecting services.

Recapturing Unreimbursed/Uninsured Care Subsidies as Health Insurance Tax Credits Expand Access.—Many hospitals receive Medicare "disproportionate share payments" (DSH) to help cover the cost of the uncompensated care they provide to uninsured patients. Medicare DSH payments will total over $2.3 billion in 1992. A significant portion of the $3.2 billion provided to teaching hospitals in fiscal year 1992 through the "indirect medical education" (IME) adjustment also is intended to help defray uncompensated care costs.

As the new health insurance tax credits and tax deductions are phased-in—to ensure that nearly everyone coming into a hospital has insurance—these subsidies would, for the most part, be unnecessary. With insurance, low-income families will be able afford primary care on an ambulatory basis—to maintain good health and prevent serious illnesses that result in the need for costly hospital admissions. (Some indigent care subsidies could be retained as "gap fillers"—to provide for the small number of remaining cases where people still fall through the cracks.)

Adjustment of IME payments is justified on other grounds. Major studies by the General Accounting Office (1991) and the Congressionally-appointed Prospective Payment Assessment Commission (ProPAC, 1990) have consistently shown that these payments are excessive even under the existing system. Therefore, a phase-down in IME payments to rates already recommended by ProPAC (on the basis of excessive payment under current law) should be possible without any harm to teaching hospitals as the burden of uncompensated care decreases with the tax credit phase-in.

Reforming Graduate Medical Education Payments.—In addition to IME payments, Medicare also makes graduate medical education (GME) payments to help cover the cost of intern and resident salaries and the cost of teaching physicians. GME payments should be reshaped to help ensure that teaching hospitals meet the Nations needs for primary care physicians in the next century. Teaching hospitals should be encouraged through payment policy to shift the primary care/specialist training mix back towards more sensible ratios that will produce more primary care physicians.

Other Possible HI Reforms.—Other reforms could further reduce the excessive growth rate in HI costs. These reforms would: ensure that Medicare pays only once for certain hospital procedures; phase out unequal and special return on investment payments to for-profit skilled nursing facilities; create specific categories of payment to recognize more home health professions; and create additional incentives to Medicare beneficiaries to enroll in coordinated care organizations.

Preventing Program Abuse

Other policy changes should be considered to address areas where there have been documented abuses of the Medicare program.

Durable Medical Equipment.—A notable example is in the area of durable medical equipment (DME). Numerous reports of fraud and abuse have prompted calls for DME payment reform. Attempts to correct overcharges by instituting a fee schedule for DME have failed.

- A recent GAO (1991) study of six DME suppliers found that the suppliers' average profit margin in 1988 was 19 percent for Medicare business, significantly more than for non-Medicare business. The GAO projected that Medicare profits would be even higher in 1993—34 percent overall. The GAO study also found that Medicare payments in 1989 were 24 percent higher under the new fee schedules than they would have been under the previous system, which was based on reasonable charges.

To bring these excessive payments under control, the Secretary of the Department of Health and Human Services should be authorized to revise DME payment rates

to reflect market considerations, using such procedures as competitive bidding to establish payment rates for oxygen and oxygen products.

Growth of Physician Payments and Related Services (SMI)

Current projections of Supplementary Medical Insurance (SMI) program costs (primarily doctor's fees) show it growing at an average annual rate of 14.6 percent from 1993 to 1997. Over the past decade, Medicare Part B payments have grown at an average annual increase of 15 percent—twice as fast as the Consumer Price Index for urban areas (CPI–U), adjusted to take into account beneficiary growth.

With the ongoing five-year phase-in of physician payment reform, many physician payments are in the process of being adjusted significantly. While it is important to let this process proceed, the payment system should be examined to remove inappropriate incentives.

A recent study done by the State of Florida has focused attention on the abusive practice of physician "self-referrals." Physicians "self-refer" when they order health care services from a facility in which they have an investment or other financial interest. The Florida study showed that physicians who self-refer utilize services at a far higher rate than physicians who do not have these financial interests (Florida Cost Containment Board, 1991). The result is a significant increase in public and private sector health care costs.

In addition, self-referrals are viewed by many as involving an unethical conflict of interest. The American Medical Association (AMA) has recognized self-referrals as an area of abuse in need of reform and has taken the position that self-referrals should generally be discouraged except in situations where physician investment is needed to make services available (AMA, 1991).

Reform legislation should consider prohibiting Medicare payment in the case of "self-referrals" in areas such as radiology, radiation therapy, durable medical equipment, home health, physical therapy, and rehabilitation where abuses have been found. Current law already prohibits Medicare payment for self-referrals involving clinical lab tests.

A number of other policy options could be developed to help restrain growth of physician fees and other SMI expenses to a rate below 14.6 percent a year. Controlling the costs of physicians payments and related services (SMI) is critical. All seniors and general taxpayers are at risk when SMI costs grow at 14.6 percent a year, because 75 percent of SMI costs are borne by the general taxpayers and 25 percent from seniors' premiums.

Chapter 6

Problems with Alternative Approaches

Many of the proposals for health system reform are patterned after one of two basic models: a centralized Canadian-style national health insurance system or an employer "play-or-pay" mandate. Both of these alternative approaches deserve careful analysis because, if they were adopted, they would have enormous consequences not only for our health care system but for our way of life and the fabric of American society. This chapter analyzes these approaches.

A. The Canadian Model

Overview

While apparently successful in many respects and highly popular with the Canadian people, the Canadian system—like all other universal public insurance systems—suffers from two basic structural flaws that are bound to lead to serious long term problems with cost, access, and quality.

- First, there are no demand side incentives for efficiency. Because medical care is free to consumers, consumers do not play the same role they play in normal markets.

  Market forces that normally produce greater economic efficiency simply do not exist. Moreover, consumers are unable to express their preferences through market choices.

- Second, major resource allocations are made centrally through the political process. Health care is too complex and too sensitive to micro-level conditions, for centralized management to be effective.

  The Canadian system relies on blunt, macro-level, supply-side constraints such as an aggregate level of expenditures, limits on high-tech equipment, and limits on physician supply.

  But, efficiency—high quality care at the lowest possible cost—requires making optimal decisions at the hospital bedside and in the physician's office.

  Central planning inevitably wastes resources and places quality at risk.

  These flaws are now increasingly apparent in the experience of the Canadian system:

- Costs have not been controlled effectively despite the enormous power that a single payer has under a universal public insurance program. Indeed, Canadian health care costs have risen slightly faster than health care cost in the U.S.

  Non-market means can moderate the growth of costs, but with significant inefficiency. Resources are often wasted on low-priority care while blunt cost containment measures limit spending where added resources could make a real difference in outcomes.

- Supply-side constraints have led to artificial shortages of critical personnel and equipment.

  Canadians have significantly less access to state-of-the-art technologies and often must wait weeks or months for treatments that are readily available to Americans. And, certain procedures, such as coronary bypass surgery, appear to be rationed, especially for senior citizens.

  Lost productivity and other costs associated with delays in surgery are estimated at 0.6 percent of Canadian GDP. These losses could be even higher if delays for

other medical services are taken into account.

- Incentives for Canadian physicians and hospitals often reward additional care regardless of its appropriateness. As a result, utilization rates have increased rapidly wasting resources.
- Reliance on crude global budgets as a means of controlling costs has forced Canadian hospitals to cut back on staffing in critical areas. As a result, post-operative death rates in Canada are 40 percent higher than in U.S. hospitals for certain high-tech, life-saving surgical operations.

Even if the Canadian system were an unqualified success, its successful adoption in the United States could not be assured. Each Nation has its own unique political, cultural, and economic environment. Experience with the Medicare and Medicaid programs in the United States suggests several difficulties in adopting a Canadian-style universal public insurance system.

- Over the past decade and a half, effective management of Medicare and Medicaid has been stymied by increasing politicization. Virtually all payment rates are fixed by law. Thus, an Act of Congress is needed to change the amount that Medicare pays for a routine lab test or X-ray.
- As a result of this inflexibility, Medicare and Medicaid per capita costs continue to grow more rapidly than per capita costs for the remainder of the population.

  If the U. S. political process has been unable to control 30 percent of health spending, there is little reason for optimism that it could be more successful in controlling costs for the entire health system.

Indeed, the thought that as much as 16 percent of the GDP by the year 2000 (32.7 percent if non health-related federal spending is included) could be subject to direct political control should give most Americans pause for serious concern.

Basic Features of the Canadian Model

For the past two decades, the ten Canadian provinces have operated government-based health insurance plans that cover hospital and physician care. The Canadian system itself, and American proposals to implement a Canadian-style approach, share a number of basic structural features:

- Health insurance is provided to all citizens through a centralized, publicly administered program. Health care services are provided by private-sector hospitals, physicians, and other providers. Private insurance is prohibited, except for services not covered by the public program.
- Covered benefits include hospital, physician, mental health, and preventive care. (Some Canadian provinces also cover prescription drugs and long-term care.) Care is free with no cost-sharing at the point of service.
- Hospitals and other institutional providers are paid on the basis of global budgets that cover all patient care costs during a year. Global budgets are set annually by government authorities, through a process that involves some element of negotiation.
- Physicians and other non-institutional practitioners and providers are paid on a fee-for-service basis according to a government-established fee schedule. Overall payments for physician services are limited by a global budget or "expenditure target."
- To control costs, the supply of facilities, equipment, and providers is strictly regulated. Hospitals are limited to government-set budgets for capital expenses. Construction projects and high-cost equipment purchases require special approval. Physician supply is limited and the specialty distribution is regulated to encourage general practice.
- Financing is primarily through broad based taxes (including a payroll tax). Some Canadian provinces also require small premium payments. Others place a special tax on employers.
- The Canadian system is administered through the provinces with supplemental Federal financing. A Canadian-style system in the U. S. could be jointly administered by federal and State governments (as proposed by Senator Kerrey) or pri-

marily by the national government (as proposed by Congressman Russo).

Basic Structural Flaws in the Canadian Model

Lack of Demand-Side Incentives.—The Canadian system lacks effective incentives for efficiency. Because medical care is free to consumers, market forces that normally drive economic systems to greater efficiency simply do not exist. This flaw could be partly remedied by requiring some cost-sharing at the point of service. The RAND health insurance experiment has conclusively shown that modest levels of cost-sharing reduce demand with little or no measurable impact on health status (Brook et al., 1983). But, the flaw in the Canadian system is much deeper than a simple lack of cost-sharing.

Because consumers do not have a choice of alternative health plans and do not pay any portion of the premium cost, there is no dynamic that could lead to the development of more efficient systems for delivering high quality care at low cost. It is no accident that innovative health care delivery systems, such as Kaiser Permanente or Group Health of Puget Sound, have emerged in the United States, but not in Canada.

In the U.S., employers and individuals, concerned about getting good value for their health care dollars, have incentives to demand better forms of health care delivery. This, in turn, creates a market for such systems, and organized health plans then compete with one another for market share, leading to progressive improvements in cost-effectiveness and quality. This consumer-driven process of progressive improvement simply cannot occur in a Canadian-style system. All significant change in Canada requires legislation.

As a result, the Canadian health care system is less dynamic, resembling the U.S. health care system as it existed in the mid-1960s. Medical care continues to be an unorganized cottage industry. Physicians are subject to little oversight to assure efficiency and quality of care. And physicians continue to be paid exclusively on a fee-for-service basis despite clear evidence that this approach is inflationary. None of the improvements in health systems delivery or innovative payment arrangements that have been developed in the United States over the past decades have taken root in Canada.

Overall, Canadian citizens as individuals are relegated to a diminished role in decision making in the health care system. Because they cannot make their own choices in the market, they are forced to rely on the vagaries of the political process.

Supply-Side Controls.—Because incentives for needed, appropriate care only are poorly structured, the government is left with controlling costs through overall supply side controls. There are at least three main problems with this approach.

- Macro-level supply side controls cannot achieve micro-level efficiency. Resources are invariably wasted. Needed services are often caught in the squeeze compromising quality and good medical care.

  Every day, medical personnel make hundreds of decisions that affect resource allocation. Should a particular test be provided? What level of staffing should be provided in a busy emergency room? Consumers also must make important decisions regarding their care.

  For efficient decisions to result, all of the participants must have appropriate incentives and must have critical information. Macro-level budget constraints do nothing to assure that proper incentives and accurate information are brought to bear.

- Supply side measures are often arbitrary and inflexible. Regulators must make thousands of decisions each year—decisions that involve billions of dollars to implement global budgets, limits on high-tech equipment, and similar measures. Regulators must decide whether to increase a hospital's budget or to approve the construction of a new cardiac surgery facility. A centralized allocation process can be cumbersome, expensive and politicized, without resulting in an efficient allocation of resources. (Deber and Leatt, 1987; Feeny et al., 1986).

- Third, a centralized allocation process may be too removed or too politicized to effectively contain costs. Broad-based political

support for cost-containment is unlikely. Lobbying by providers and special interest groups, partisan disputes, and a host of other complications make success in containing costs problematic, at best.

Canada: The Evidence to Date

The preceding discussion suggests that the design inherent in any centralized, government-controlled health insurance scheme will have adverse impacts on costs, access, appropriate use of resources, and quality. In fact, a growing body of evidence strongly suggests these are characteristics of the current Canadian system.

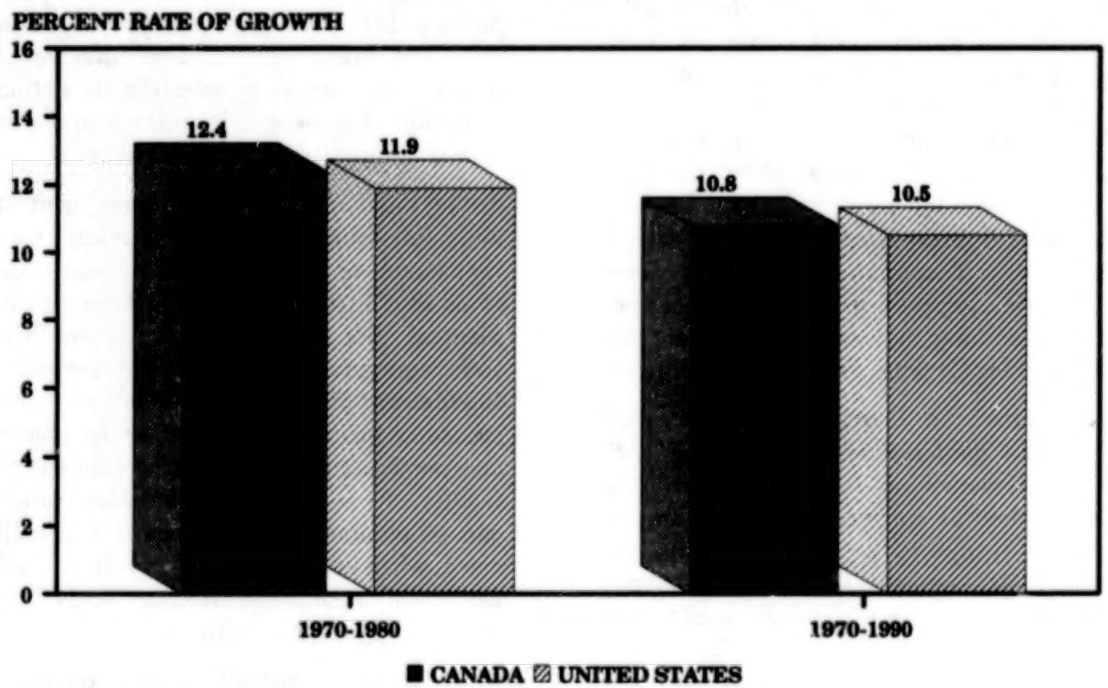
Failure to Control Cost Growth.—Even with strict global budgeting and some rationing of care, Canadian health costs continue to grow faster than U.S. costs. Between 1970 and 1980, Canada's annual compound rate of growth for per capita health expenditures was 12.4 percent, compared with 11.9 percent in the U.S. Between 1970 and 1990, Canada's expenditures grew annually 10.8 percent, compared with 10.5 percent in the U.S. (OECD, 1990; Schieber et al., 1991).

Cost-containment also has become more difficult in Canada in recent years. Rising demands on the system resulting from free universal access have placed increased financial burdens on the government.

Declining national contributions and cost-containment measures have initiated a recent round of hospital staff layoffs and bed closings. Ontario, for example, the richest and most populous province, where more than a third of the Canadians live, has lost nearly 5,000 hospital jobs and 3,500 beds over the last two years. In Toronto, the provincial capital, 2,900 of 15,000 acute-care beds have been taken out of service (Media Digest, November 25, 1991).

To contain costs, Canada has cut payments to providers, making the yearly price negotiations more and more difficult. The rising Canadian costs, kept artificially under control by government price and spending caps, have been described as "a pressure cooker that

Chart 21. COMPOUND ANNUAL PERCENTAGE RATES OF PER CAPITA NOMINAL GROWTH



SOURCE: OECD, "OECD Health Systems: Facts and Trends" (Paris: OECD forthcoming)

is building steam on a hot stove" (Iglehart, 1986).

Treatment Delays.—Reliance on supply constraints to control costs inevitably leads to shortages and delays in treatment. Canadians must often wait to receive treatment. For example, Canadians wait on average 4.9 months for open heart surgery, and 5.5 months for bypass surgery (Globerman, 1990).

These waiting times for medical treatment can have potentially adverse effects on a patients' health. Patients not receiving timely access to diagnostic procedures—such as MRIs, CT scans and mammograms—can suffer setbacks due to delayed treatment. Those waiting for acute procedures—such as open heart surgery—can risk death waiting for care.

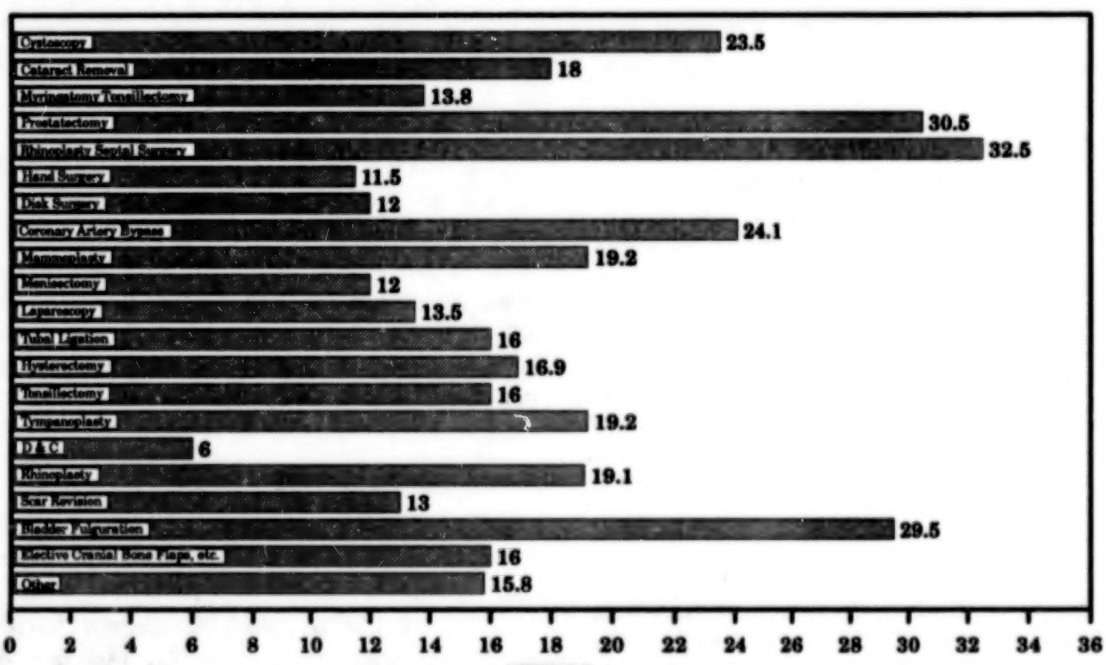
Waiting for treatment also results in a direct economic loss. If unable to work while waiting for care, individuals may face financial setbacks. Some may even lose their jobs. There is the additional social loss of productivity. The overall cost of delays in surgery has been estimated at 0.6 percent of Canadian GDP (Danzon, 1991).

Limited Access to Advanced Technology.—Government control of hospital capital and operating budgets limits the adoption of medical technology in Canada. For example, U.S. citizens have access to more open heart surgery, cardiac catheterization, organ transplants, radiation therapy, extracorporeal shock and lithotripsy, and magnetic resonance imaging.

Data from Anderson et al. (1989) also suggest rationing of selected expensive procedures for older age groups. Heart valve surgery and bypass surgery for patients ages 65–74 and 75+ were consistently performed less often in Canada. For patients age 75 and above, a full 4 times as many bypass procedures were performed in the U.S. as in Canada for the same age group of patients.

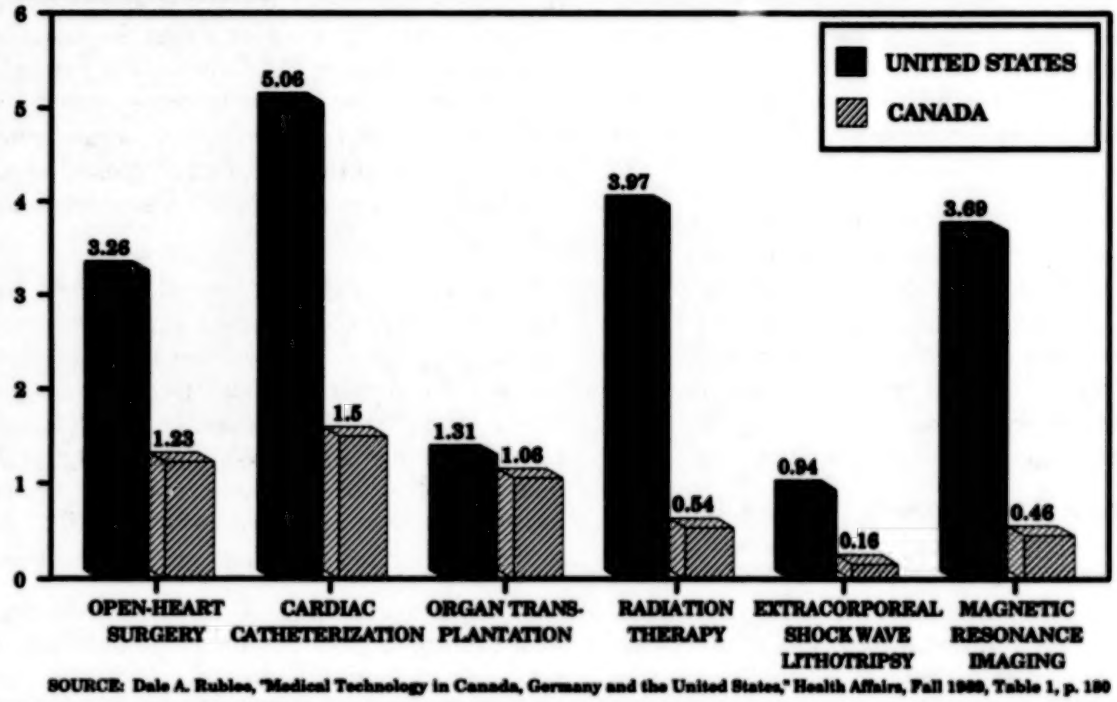
Limited availability of medical technology has prompted the Canadian government to send some patients to the U.S. to seek advanced medical care. For example, the

Chart 22. AVERAGE WAITING TIMES IN BRITISH COLUMBIA



SOURCE: Steve Globerman, Waiting Your Turn: Hospital Waiting Lists in Canada (Vancouver: Fraser Institute, 1990)

Chart 23. ACCESS TO MODERN MEDICAL TECHNOLOGY UNITED STATES (1987) VS. CANADA (1989)



SOURCE: Dale A. Rublee, "Medical Technology in Canada, Germany and the United States," Health Affairs, Fall 1989, Table 1, p. 180

British Columbia Health Association has contracted with Seattle hospitals for coronary bypass surgeries (Washington State Hospital Association, 1990), and Ontario and Alberta have similarly contracted with U.S. hospitals for high technology care (Goodwin, 1990; Sherlock, 1990).

While these instances may be rationalized as temporary problems, the Canadian system is able to use access to U.S. technology as a "safety valve." Since the U.S. provides an available supply of medical technology just across the boarder, Canada may have an incentive not to invest in sufficient supply. If the U.S. were to adopt a Canadian system, this safety valve would no longer exist for Canada, nor would one exist for Americans (HIAA, 1990).

Limited hospital budgets for capital improvements also have meant that the physical plant and equipment in many hospitals is nearing obsolescence (Iglehart, 1986). This lessens some Canadian hospitals' ability to provide the highest quality care.

Ineffective Use of Resources Resulting from Inappropriate Incentives.—Because Canada continues to rely primarily on fee for service payment, physicians are rewarded for additional care regardless of need or quality. As a result, utilization per physician increased by 25.1 percent in Canada between 1971 and 1985, compared with only 7.0 percent in the United States (Barer et al., 1988). Overall, Canadian physicians provide a much higher volume of services than U.S. physicians. While data is not available on rates of appropriateness, these substantially higher levels of medical utilization raise concerns about the amount of inappropriate and unnecessary care being delivered and paid for by the Canadian taxpayer.

Hospitals also face perverse incentives. Because hospitals are paid a fixed aggregate budget, they have a financial incentive to use available beds for patients with the lowest cost. As a result, Canadian hospitals are filled with chronically ill, but low cost, patients, termed "bed blockers."

Table 6–1. Relative Use of Physician Services in Canada and the United States

(Services per capita)

Service Type	Canadian Rate as Percent of U.S. Rate
Diagnostic and Therapeutic Procedures	120
Office Visit and Consultations	156
All Physician Services	139

Source: Fuchs, 1990.

These incentives affect quality and hospital staffing decisions. Canadian hospitals have lower average staff-to-patient ratios than do U.S. hospitals, (1.87) versus (3.47) (Newhouse et al., 1988). Quality for high-risk patients, however, can suffer as a result of these staffing patterns (see below).

Pressures on Quality.—Roos et al. (1989) recently compared Canadian and U.S. post-operative mortality rates. Interestingly, Canadian hospitals did as well as U.S. hospitals on low risk surgical procedures. Post-operative mortality, however, is 44 percent higher in Canada than in the U.S. for high risk procedures including heart surgery. This outcome may result from hospital budgeting practices which encourage lower staff-to-bed ratios. This means that patient care resources might not be available when critically needed.

Quality assurance activities such as peer review, second opinion, utilization management and outcomes information also are relatively undeveloped in Canada compared with the United States. Similarly, Canadian hospitals have few incentives to compete on increased quality of care. Because of tight budgets, hospitals in Canada do not invest to any significant level in data collection and quality review.

Could a Canadian-Style System Be Successfully Implemented in the United States?

Critical Differences Between the United States and Canada.—The notion of simply adopting the Canadian system is simplistic. Each nation has its own unique political, cultural, and economic environment and history.

One major difference between the United States and Canada is our form of government. We rely on a system of checks and balances, with independent executive, legislative, and judicial branches. Canadians, in contrast, have a parliamentary form of government, which

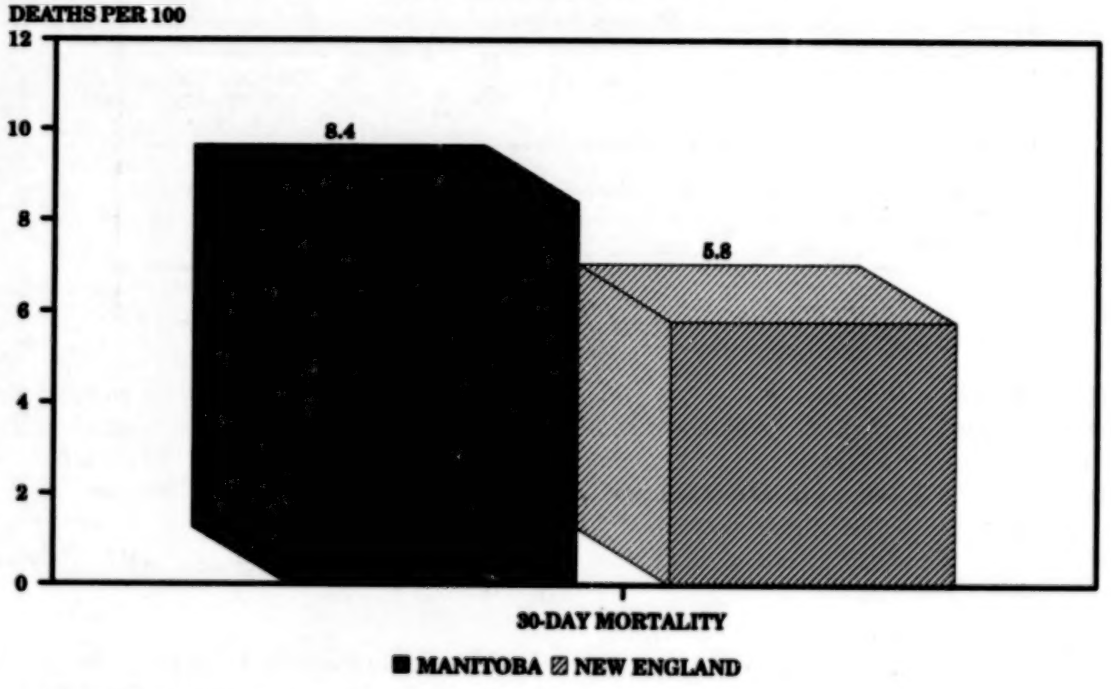
Table 6–2. Comparison of Hospital Care in Canada and the United States

(Use rates for people aged 65 and older)

	Unites States	Canada	Canadian Rate as Percent of U.S. Rate
Admissions Per Capita	0.33	0.35	106
Length of Hospital Stay (in days)	7.96	13.32	167
Hospital Days Per Capita	2.63	4.66	177
Hospital Staff Per Occupied Bed	3.47	1.87	54

Source: Newhouse, 1988.

Chart 24. POST-OPERATIVE MORTALITY FOR HIGH RISK SURGICAL PROCEDURES FOR PATIENTS 65 AND OLDER



SOURCE: Roos, et al., JAMA, Vol. 263, No. 18, May 9, 1990

effectively combines legislative and executive functions. There is less potential in Canada for the political deadlock that has characterized health policy in the United States over the past decade.

Experience with the Medicare and Medicaid Programs.—Experience with the Medicare and Medicaid programs suggests that a Canadian-style universal public insurance program could not be translated successfully into the United States. While these programs have succeeded in expanding access to the elderly, the disabled and many low income Americans, these programs have become increasingly politicized over the past 10 years thwarting effective program management.

When enacted in 1965, Congress delegated broad responsibility for management of Medicare and Medicaid to the executive branch and to the States. Congress legislated only the broad outlines of the programs and limited its role to oversight. Today, virtually every detail of operation of Medicare and Medicaid is dictated in hundred of pages of dense legislative language that are comprehensible only to a handful of Congressional staff and executive branch experts.

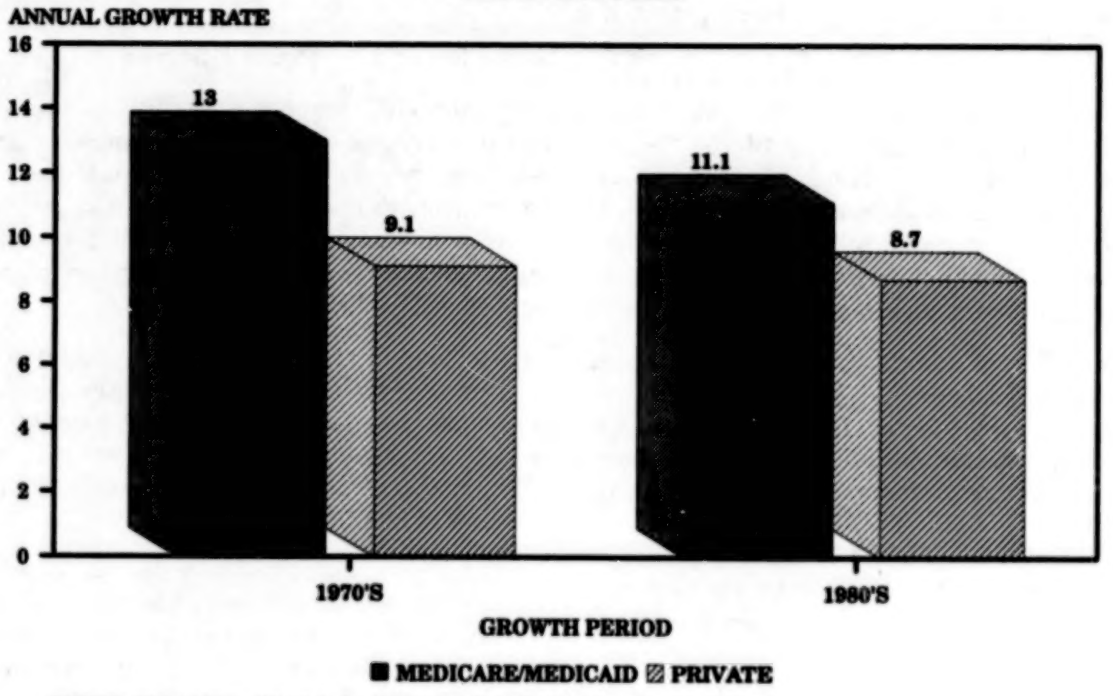
With the increasing complexity of the legislation, few Members of Congress even have an opportunity to vote on the issues involved. Over the past decade, the full House and Senate have only had a handful of opportunities to debate and vote on critical programmatic issues.

Micromanagement of program details by legislators may be inevitable because it extends the political power and influence of key committee members. The technical details of payment policy often are highly arcane but of great monetary significance. Many payment policies are somewhat arbitrary.

Per capita health care costs for Medicare and Medicaid recipients have grown consistently faster than per capita health care costs for the remaining population.

If the political process has been unable to control 30 percent of health spending, there is little reason for optimism that it

Chart 25. ANNUAL GROWTH IN PER CAPITA HEALTH CARE EXPENDITURES



SOURCE: HCFA, Office of the Actuary, Office of National Health Statistics

could be more successful in controlling costs for the entire health system.

Potential for Massive Transition Costs and Disruptions.—Establishing a universal public insurance program in the United States would involve massive transition costs and disruptions. Either taxes and government spending (federal and/or State) would have to increase by $250 to $500 billion per year, and either taxes or government borrowing would rise by the same amount. Using 1992 dollars or cost controls would have to cut enlisting problems and expenditures by an equivalent amount. Either tax increases or program costs of this magnitude would have devastating effects. If coverage is financed through a payroll tax that would increase the cost of employment, job losses could exceed two million workers. Millions of people currently satisfied with their current insurance arrangements would be forced to switch their coverage.

B. Problems with "Play-or-Pay"

Overview

"Play-or-pay" is a widely discussed approach for expanding health insurance access. Employers would be required to "play", e.g., provide private insurance for workers and dependents, or "pay" a payroll tax to fund public insurance for their workers and dependents. Variants of this approach have been proposed by Senators Mitchell and Kennedy and by Representative Rostenkowski, among others.

While "play-or-pay" would expand insurance coverage, it suffers from four serious drawbacks. "Play-or-pay" would:

- Hurt workers by reducing jobs and by forcing employers to cuts wages to offset mandate costs. While "play-or-pay" seems to put the burden on employers, this is large-

ly an illusion. Employers will inevitably shift the burden to employees. Between 350,000 and 750,000 jobs could be lost in the short-run, with a long-term potential as high as two million. These job losses are about 50 percent to 100 percent of those endured during the recession. Moreover, cash wages for many of the "beneficiaries" of the mandate would decrease by 7 to 9 percent depending on the payroll tax rate, and would fall by about another 1 percent as newly unemployed workers compete for increasing scarce jobs.

- Cascade into a form of national health insurance. "Play-or-pay" is inherently unstable. According to the Urban Institute, 60 million workers and dependents who now have private coverage would be shifted into the public plan. Overall, 58 percent of Americans would be insured publicly. At this point, the public could use its near-monopsony position to gain deep discounts from providers resulting in a massive cost-shift that would rapidly price the remaining private coverage out of the market.
- Hurt small business. While the $30 billion cost of the mandate will be shifted to workers, in the near-term, employers will bear the burden. Some employers may try to pass this added cost on to consumers in the form of higher prices. But many businesses that do not currently provide coverage have low profitability, are engaged in competitive markets and may fail as a result of the higher costs. Small business will suffer disproportionately.
- Increase costs for government over and above the new payroll tax receipts. "Play-or-pay" is not self-financing. A federal subsidy would be needed to fund the gap between payroll tax receipts and actual costs, and this gap is likely to grow rapidly. Although premium costs average 7 percent of payroll, actual costs vary widely. Low-wage firms incur costs well in excess of 7 percent. These firms will disproportionately opt to "pay," but the tax will be inadequate for health coverage for these firms. This problem will be compounded by the fact that premium costs also vary widely. Firms with higher premiums due to an older or sicker work force would have a strong incentive to opt into the public plan, further undermining the solvency of the plan.

How Play-or-Pay Plans Operate

"Play-or-pay" employer mandates are designed to provide coverage for workers and their dependents with little direct cost to government. Employers are required to provide coverage directly or pay a payroll tax. Mandates typically apply for all workers employed more than 17.5 hours a week.

- To "play," employers would be required to provide "basic" health coverage. Typical employers could require workers to pay up to 20 percent of premium costs as well as make modest copayments upon the receipt of health care.
- Employers not providing health benefits directly would be required to pay a payroll tax to cover a portion of the cost of benefits provided through a public insurance program. Estimated payroll tax rates are in the range of 7 to 9 percent. Generally, there is no cap on the taxable wage base.

"Play-or-pay" mandates usually are accompanied by an expanded public insurance program to replace Medicaid and provide subsidized coverage on a sliding-scale basis for those without employer-paid coverage or Medicare. Some form of price regulation also generally accompanies "play-or-pay" proposals as a means of restraining costs. The regulation may involve some form of payer/provider negotiations or may be administered directly by a regulatory agency.

Characteristics of the Working Uninsured

The working uninsured are the intended beneficiaries of "play-or-pay" mandates. In 1987, almost half (47.4 percent) of uninsured workers earned $5 or less an hour. Sixty percent were employed in small establishments with 25 or fewer workers. Most worked in low-skilled occupations and in industries that are characterized by intense competition and comparatively low profitability. Many of these low-wage workers will be those who would lose their jobs under play-or-pay.

Consequences of "Play-or-Pay"

Effects on Insurance Coverage.—From the standpoint of expanding insurance coverage "play-or-pay" appears to be a success. According to a simulation conducted by analysts at the Urban Institute, an estimated 33 million uninsured Americans and their dependents would receive insurance coverage as a result of the mandate—22 percent through their employer and 78 percent through the new public plan.

Assuming a 7 percent "play-or-pay" tax, insurance costs would increase by $30 billion for employers, in 1989 dollars, and by $37 billion for employers with a 9 percent tax. Premiums paid by individuals would increase by less than $1 billion, while uncompensated hospital care would decrease by $15 billion.

The Effects on Wages and Employment.—"Play-or-pay" mandates appear to put the burden on employers, but in the long-run, the burden falls primarily on workers. The effects are two-fold: lower real take-home pay and fewer jobs.

The reason is straightforward. At the margin, the total compensation an employer is able to pay (including wages and fringe benefits) must equal the marginal value to

Table 6–3. Shifts In Insurance Coverage for the Under 65 Population

	Employer Sponsored Insurance	Private Nongroup	Government (Excluding Medicare)	Uninsured
Number of People Covered in Millions:				
Current System	142	18	23	33
Under Pay-or-Play:				
With a 7 percent tax	105	0	112	0
With a 9 percent tax	132	0	85	0
Percentage of Population Covered:				
Current System	66	8	11	15
Under Pay-or-Play:				
With a 7 percent tax	48	0	52	0
With a 9 percent tax	61	0	39	0

Table 6–4 Insurance Costs
(Billions of 1989 dollars)

	Total	Employers	Individuals	Government
Total Insurance Costs:				
Current System	202	129	46	28
Under Pay-or-Play:				
With a 7 percent tax	269	159	46	64
With a 9 percent tax	272	173	46	53
Added Insurance Costs:				
With a 7 percent tax	67	30	0	36
With a 9 percent tax	70	44	0	26
Less Savings from Reductions in Uncompensated Care:				
With a 7 percent tax	15	—	—	—
With a 9 percent tax	15	—	—	—
Net Added Insurance Costs:				
With a 7 percent tax	52	—	—	—
With a 9 percent tax	55	—	—	—

the employer of the labor that is provided. If an employer is forced by a government mandate to increase benefits, the employer will reduce employment or reduce cash wages. A mandate simply cannot force an employer to pay more in compensation than the value of the labor to the employer. This conclusion is supported by a number of empirical studies analyzing other mandates (see, e.g., Gruber and Krueger, 1990).

For uninsured workers, the cost of keeping their jobs with a 7 percent "play-or-pay" payroll tax would be a 7 percent reduction in gross wages, and a larger proportionate drop in after-tax income. In addition, wages, corrected for inflation, would fall by about another 1 percent as newly unemployed workers compete for fewer jobs. The burden would be particularly great because most of the working uninsured are low-wage workers already struggling to make ends meet. For example, the mandate would result in—

- A pay cut of $1,680 a year for the average 30 year old male high-school graduate, currently earning $24,000 a year in wages; and
- A pay cut of $1,260 a year for the average 30 year old male high-school dropout, currently earning $18,000 a year in wages.

For other workers, 350,000 to 700,000 jobs would be lost. Moreover, if the "play-or-pay" mandate evolves into a universal public insurance program, available to all regardless of employment, job losses could reach two million.

A review of the characteristics of the uninsured workers makes these predictions seem even more realistic. Most of uninsured workers are low-wage, low-skilled workers. These workers have little ability to command costly fringe benefits.

A better approach is to provide direct assistance for low-income workers through tax credits, as the President has proposed. This approach is more "progressive" in terms of income distribution. Income is transferred directly to assist low-income workers, without the risk of job loss or a reduction in wages that a mandate inevitably involves.

"Play-or-pay" has other disadvantages for workers as well.

- With a 7 percent payroll tax, 52 million currently insured workers and dependents with employer-based plans would be forced to change coverage. Another 14 million Americans would be forced to give up their private insurance and would be forced into a "one size fits all" public insurance plan. These shifts in coverage are illustrated in Table 6–5.
- Families that depend on supplemental income from part-time employment of a spouse could be hurt. If the mandate applies to part-time work. Employers will cut back on part-time jobs because of the added cost. On the other hand, if the mandate does not apply, it would fail to close an important gap in coverage and government would be forced to pick up the costs through the back-up public plan.

Table 6–5. 66 Million Lose Choice of Plan Under Play-or-Pay
(Coverage under new public plan in millions)

	Workers	Dependents	Nonworkers	Total
With a Pay-roll Tax of 7 Percent				
Former Source of Coverage:				
Employer	37	15	0	52
Private Insurance	6	2	6	14
Government	2	4	13	19
Uninsured	12	6	8	26
Total	57	27	28	112

A Backdoor to National Health Insurance

Advocates present "play-or-pay" as means of providing universal coverage while avoiding national health insurance with all of its shortcomings. (See Chapter 6.A.) But, this argument is flawed. "Play-or-pay" is inherently unstable and will likely collapse into a full blown national health insurance system.

Many employers who now provide private health insurance to their workers will have strong incentives to shift coverage to the public plan "pay" option because a 7 or even 9 percent payroll tax will be significantly less costly than private coverage. The incentives are particularly great for small firms with comparatively low average wages. A recent study conducted for the Labor Department by policy analysts at the Urban Institute reaches some startling conclusions on the potential size of such a shift.

With a 7 percent payroll tax, total enrollment in public insurance (including Medicare) would be 144 million or 58 percent of the population. Sixty-six million Americans with private coverage would be shifted to the new public plan. Twenty-six million of the 33 million who are currently uninsured would end up in the public plan. Only 7 million would actually receive health insurance through their employers.

For workers in small firms, private health insurance would quickly become a thing of the past under "play-or-pay". At a 7 percent tax, 81 percent of the workers in firms with 25 workers or less would be enrolled in the public plan. Even with a 9 percent payroll tax 117 million, or 47 percent of the total population would be covered by public insurance. Thirty-two million Americans who currently have private employer-paid coverage would shift into the new public plan as would 22 million of the currently uninsured.

It is important to note that the Urban Institute study focused only on the "static" effects of a "play-or-pay" mandate. Once a "play-or-pay" system is in effect, however, dynamic forces will be set in motion that drive the system further toward universal public coverage.

In the absence of other reforms, health care costs are likely to increase much more rapidly than wages. As a result, the public plan will become increasingly underfunded unless the payroll tax is increased to keep up with health care inflation. But, due to political pressures, the Congress is unlikely to let this happen. So, the Congress is likely to turn increasingly to general revenues to subsidize the public plan. Or the Congress may try to use some form of blunt price regulation to hold down public plan costs. Either way, the public plan would gain an increasing competitive advantage over private health plans, and private health plans would rapidly lose market share.

Effects on Employers

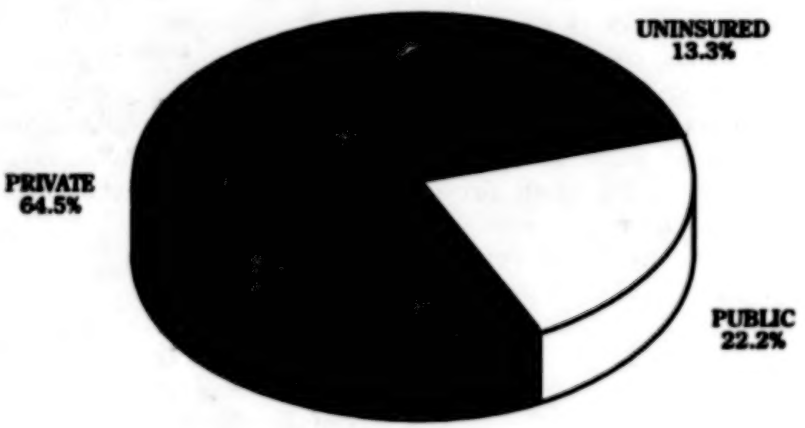
In the short-run, employers will not be able to react fully to the mandate by reducing wages or employment. As a result, the initial harmful effects of the mandate will fall mainly on employers. Small firms would be especially hard hit.

- Health insurance costs for employers would increase by $30 billion under a mandate with a 7 percent payroll tax—a 23 percent increase in current health insurance costs. With a 9 percent tax, the added cost for employers would be $44 billion—a 34 percent increase in insurance costs.
- The largest proportional increases would be for small employers. For firms employing fewer than 25 workers, costs would rise by 71 percent with a 7 percent payroll tax rate, and by 101 percent with a 9 percent tax. As noted, 60 percent of currently uninsured workers are employed in establishments with 25 or fewer workers.

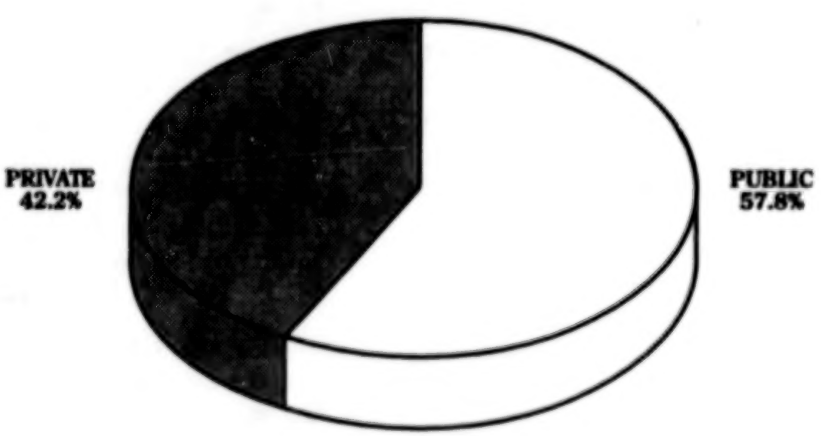
In the short run, a "play-or-pay" mandate will lead to somewhat higher prices and an increase in the inflation rate. For firms, that cannot pass on increases in costs through higher prices, there would be a fall in profits. Assuming the monetary authorities maintain their existing targets for inflation, the effect of the mandate would be to lower employment and lower real GDP.

Chart 26. SOURCE OF HEALTH INSURANCE COVERAGE FOR U.S. POPULATION

CURRENT SYSTEM



PAY-OR-PLAY WITH A 7% TAX



SOURCE: The Urban Institute, "Pay or Play Employer Mandates: Effects on Insurance Coverage and Costs," January 8, 1992

The Cost to the Government of "Play-or-Pay"

A "play-or-pay" mandate would give rise to a vast new federal health insurance program, four times as large as Medicaid and inadequately funded.

The Urban Institute estimates that a pay-or-play mandate with a 7 percent payroll tax would not be adequately funded. The new payroll tax would not cover the full cost of the new public plan. A subsidy of $37 billion would be needed from general revenue. A 9 percent payroll tax would lower the subsidy to $25 billion. The subsidy is likely to grow over time for reasons noted previously.

"Play-or-Pay" Fails to Address Cost-Control Effectively

Play-or-pay proposals are often coupled with "all-payer" price regulation schemes that attempt to limit aggregate payments by all public and private insurers to hospitals, physicians, and other providers to pre-set global budget targets. These schemes are closely related to Canadian-style national health insurance plans and share the same drawbacks.

All-payer rate setting preserves a role for private insurers, but is otherwise identical to a Canadian-style system in relying on supply-side constraints to control costs. Neither approach addresses the dynamic factors that are driving up health care costs.

In the absence of meaningful reforms, imposing price controls is like putting lid on a pressure cooker. If the heat remains, the lid eventually blows off and the pot boils over. The disadvantages of the Canadian system are discussed in detail elsewhere. Problems with all-payer rate setting are briefly summarized here (see Table 6–6).

Although advocates often argue that all-payer rate setting would encourage coordinated care plans, the opposite seems more likely to be the case. All payer rate setting robs coordinated care plans of their cost-savings advantage relative to traditional fee-for-service arrangements by artificially holding prices down.

The more rate setting succeeds in controlling costs, the less incentive that consumers (and therefore providers) will have to switch to coordinated care. So, all-payer rate setting, like Canadian-style national health insurance, seems likely to preserve inefficient forms of service delivery.

Table 6–6. Potential Problems with All-Payer Rate Setting

1. Supply constraints will lead to shortages and waiting lines. Tight global budgets will force hospitals to cut back on personnel in critical areas—jeopardizing the quality of patient care.
2. Rate setting fails to reward efficient physicians while creating incentives for overutilization.
3. Rate setting fails to reform incentives/structure/organization at the micro-level and so will lose effectiveness with time.
4. Rate setting will reduce the competitive edge of coordinated care—thereby retarding critically needed change in the delivery system.
5. Primary reliance on all-payer regulation to control costs opens up a broad range of issues to political interference and manipulation.

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Chapter 7

Examples of Impacts on Individuals and Families

The President's plan will allow all Americans to have access to affordable health insurance. The following are illustrative examples of how the President's plan would work.[1]

Case #1

A family of two parents and a child with one working parent without employer coverage, and a total family income of $10,000 (just below the poverty level):

[Full Credit of $3,750]

- Under the current system, this family is not eligible for Medicaid and cannot afford private health insurance.
- Under the President's plan, this family would qualify for a $3,750 transferable credit to buy basic health insurance through the State designed group health plan (or another of their choice).

Case #2

A mother with two children who was on welfare (AFDC) in the past, and has returned to a job earning $8,500 per year. No employer health insurance is provided:

[Full Credit of $3,750]

- Under the current system, a mother receiving AFDC who returns to work continues to receive Medicaid for six months; after the six-month period, the family may be charged three percent of the family income as a Medicaid premium in this case, $255 for six months of coverage. After one year, the family is no longer eligible for Medicaid.
- Under the President's plan, the family would qualify for a $3,750 transferable credit to buy basic health insurance through the State group health plan (or another private plan) when they no longer qualify for Medicaid.
- The President's plan removes the current incentive for AFDC families to remain on welfare because they fear losing Medicaid coverage—the President's plan will ensure continued coverage for welfare recipients who return to work.

Case #3

A family of four with a modified adjusted gross income of $60,000 (in which the filer is married and filing jointly), and no employer sponsored health insurance:

[Full Health Care Deduction of $3,750 and Access to Group Coverage]

- Under the current system, they often cannot find affordable coverage.
- Under the President's plan they would receive a $3,750 tax deduction (a benefit of approximately $1,050) to help with the purchase of insurance.
- In addition, their employer(s) would provide information and arrange access (but not be required to contribute) to group coverage. For example, the employer could arrange coverage through a Health Insurance Network (HIN), so that the family could buy more affordable coverage through a large group—with larger risk pools rather than costly individual coverage.

Case #4

A single individual with intermitent income at the minimum wage and not eligible for Medicaid (e.g. most males or a woman who is not a mother):

[Individual Credit of $1,250]

- Under the current system, this individual has no access to health insurance, and

[1] The examples presented assume the fully-phased in program, and use 1993 income thresholds.

usually receives "unreimbursed care" through hospital emergency rooms.

- Under the President's plan, this person would receive a $1,250 transferable credit for the purchase of group health insurance through the basic State health plan, or some other private plan.

Case #5

A family of four with a modified adjusted gross income of $50,000, and a $1,000 employer contribution to health insurance:

[Health Care Deduction]

- Under the President's plan, this family would receive a health care tax deduction of $2,750 ($3,750 minus employer contribution of $1,000), making their health insurance much more affordable.

Case #6

An individual with a serious health problem is considering changing jobs, but is afraid of giving up current employer coverage:

[Portability and Security of Health Care]

- Under the current system, a person changing jobs may not be covered under a new employer's policy because of health status. A pre-existing condition exclusion may also apply, interrupting coverage.
- Under the President's plan, regardless of the employee's health status, the new insurer would be required to offer unrestricted access to the new employer's group coverage.
- In addition, insurers would not be permitted to deny coverage due to health status, and persons with previous health benefits could not be denied coverage of pre-existing conditions. (So long as no insurer can avoid pre-existing conditions, and all must accept new risks, no insurer will be disadvantaged.)

Case #7

An employer of a small firm of 20 workers would like to offer employees health insurance, but cannot find affordable coverage:

[Small Market Reforms]

- Under the current system, small employers have difficulty finding affordable coverage. The problem becomes worse when one member of a small group has a poor medical history or current high medical costs.
- Under the President's plan, small employers would have access to larger group coverage through Health Insurance Networks (HINs) spurred by major insurance and ERISA reform. Large group coverage is less expensive and more efficient, since insurance administrative costs are much lower and risk is more effectively distributed.
- In addition, the plan would set limits on the variation of premiums insurers could charge to different groups. Insurers would not be able to deny coverage to any individual, or drastically increase premiums when one member of a group becomes ill.

Case #8

A small employer with an employee just diagnosed with a serious health problem applies for health insurance for the first time:

[Guaranteed Coverage Issue]

- Under the current system, uninsured persons with serious health problems are often denied health insurance—at any price.
- Under the President's plan, insurers would be required to offer coverage to any group, regardless of health status. Premium levels would be limited so that costs would not be prohibitive.

Case #9

A family of four with a modified adjusted gross income of $17,000 has no employer coverage and currently cannot afford health insurance:

[Partial Health Credit]

- Under the President's plan, this family would receive a partial health tax credit towards the purchase of health insurance (or a $3,750 deduction—whichever provides the greater benefit) because their in-

come faces between 100 percent and 150 percent of the tax threshold.

- Affordable group coverage would be made available through a State coordinated "basic plan" pool that would guarantee access to basic health insurance coverage.

Case #10

An individual is planning on choosing a health plan and wants to get the best quality plan for the best price. But he is unsure of which plan to choose:

[Consumer Information]

- Under the current system, consumers have limited knowledge of the relative prices of insurance an health care services. Nor are they aware of the hospitals and doctors included in the plan—or of the relative quality of local hospitals and doctors.
- Under the President's plan, comparative information on quality and price of health care will be available to consumers and large purchasers of care. State insurance commissioners will collect information on area providers, and also on individual providers such as physician, hospitals, labs and other facilities—both on price and quality. This information will be made available by employers. A type of local health care market "blue book" will allow consumers to identify the best health plans, and providers. As a result, consumers will be better equipped to choose the health plan or provider best suited to their needs and the best value for their health care dollar.

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References

Agency for Health Care Policy and Research, National Medical Expenditures Survey, U.S. Public Health Service, Rockville, MD, 1987.

American Medical Association, Socio-economic Monitoring System, 1983 and 1989, core surveys, Chicago, Illinois.

Anderson, G.M., Newhouse, J.P., Roos, L.L., "Hospital Care for Elderly Patients with Diseases of the Circulatory System: A Comparison of Hospital Use in the U.S. and Canada," *New England Journal of Medicine,* Vol 321, 1989, pp. 1443–1448.

Barer, M.L., Evans, R.G., and Labelle, R.J., "Fee Controls as Cost Controls: Tales from the Frozen North," *Milbank Mem Fund Q/Health & Society,* Volume 66, p.1–64, 1988.

Barer, M.L., Evans, R.G., and Stoddart, G.L., "Controlling Health Care Costs by Direct Charges to Patients: Snare of Delusion?" Occasional Paper 10 (Toronto: Ontario Economic Council, 1979).

Brennan, T.A., Leape, L.L., Laird, N.M., et al., "Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I.," *New England Journal of Medicine,* Volume 324, pp. 370–376, 1991.

Brook, R.H., Ware, J.E., Rogers, W.H., Keeler, E.B., Davies, A.R., Donald, C.A., Goldberg, G.A., Lohr, K.N., Masthay, P.C., Newhouse, J.P., "Does Free Care Improve Adults' Health?," *New England Journal of Medicine, pp.* 1426–1434, December 8, 1983.

Chernick, H.A., Holmer, M.R., and Weinberg, D.H., "Tax Policy Toward Health Insurance and the Demand For Medical Services," *Journal of Health Economics,* pp. 1–25, 1987.

Congressional Research Service, Cost and Effect of Extending Health Insurance Coverage, Library of Congress, Washington, D.C., October, 1988.

Cunningham, F.C. and Williamson, J.W., "How Does Quality of Health Care in HMO's Compare to That in Other Settings? An Analytic Literature Review: 1958 to 1979," *Group Health Journal,* Volume 1, Number 4, 1980.

Current Population Survey, U.S. Department of Labor, Washington, D.C., 1988.

Current Population Survey, U.S. Department of Labor, Washington, D.C., 1991.

Darman, R., "Introductory Statement: The Problem of Rising Health Care Costs," Testimony before the Finance Committee, U.S. Senate, Washington, D.C., April 16, 1991.

Darman, R., "Comprehensive Health Reform: Observations About the Problem and Alternative Approaches to Solution," Testimony before the Ways and Means Committee, U.S. House of Representatives, Washington, D.C., October 10, 1991.

Danzon, P.M., "The Hidden Costs of Budget-Constrained Health Insurance Systems," American Enterprise Institute for Public Policy Research Conference, Washington, D.C., October 1991.

Deber, R.B. and Leatt, P., "Technology Acquisition in Ontario Hospitals: You Can Lead a Hospital to Policy, But Can You Make It Stick?" In: Home JM, (ed.) *Proceedings of the Third Canadian Conference on Health Economics,* Winnipeg: University of Manitoba, pp. 259–277, 1987.

Doherty, R.B., "Wishful Thinking and the Clamor Over Administrative Waste," The Internist, pp. 22–27, May 1991.

Dowd, B.E., "HMO's and Twin Cities Admission Rates," *Health Services Research,* Volume 21, pp. 177–188, Part I, June 1986.

Consumer Checkbook, *Washington Consumers' Checkbook Magazine,* Washington, D.C., 1982.

Employee Benefit Research Institute, "EBRI Issue Brief," Washington, D.C., February 1989.

Enthoven, A. "Competition of Alternative Delivery Systems," In *Competition in the Health Care Sector,* W. Greenberg, (ed.) Aspen Systems, Germantown, MD, 1978.

Enthoven, A.C., "Consumer-Choice Health Plan: A National-Health-Insurance Proposal Based on Regulated Competition in the Private Sector," *New England Journal of Medicine*, Volume 298, p. 709, 1978.

Enthoven, A.C., *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care*, Addison-Wesley Publication Co., Reading, Massachusetts, 1980.

Farley, P.J., Monheit, A.C., "Selectivity in the Demand for Health Insurance and Health Care," *Advances in Health Economics and Health Services Research*, R. Scheffler and L. Rossiter (ed.), JAI Press, Greenwich, CT., pp. 231–248, 1985.

Feeny, D., Guyatt, G., Tugwell, P., "Health Care Technology: Effectiveness, Efficiency and Public Policy," Institute for Research in Public Policy, Montreal, 1986.

Feldman, R.D. and Dowd, E.E., "Simulation of a Health Insurance Market with Adverse Selection," *Operations Research* Volume 30, pp. 1027–1042, Nov-Dec 1982.

Feldman, R., et al., "The Competitive Impact of Health Maintenance Organization on Hospital Finances: An Exploratory Study," *Journal of Health Politics, Policy and Law*, Volume 10, pp. 675–698, Winter 1986.

Feldstein, M.S., *Hospital Costs and Health Insurance*, Harvard University Press, Cambridge, Mass., 1981.

Feldstein, M.S. and Taylor, A., "The Rapid Rise of Hospital Costs," President's Council on Wage and Price Stability, Washington, D.C., 1977.

Feldstein, M.S. and Friedman, B., "Tax Subsides: The Rational Demand for Insurance and the Health Care Crises," *Journal of Public Economics*, Volume 7, pp. 155–78, April 1977.

Feldstein, P.J., *Health Care Economics*, A Wiley Medical Publication, John Wiley & Sons, 1988.

Florida Health Care Cost Containment Board, "Joint Ventures Among Health Care Providers in Florida," Tallahassee, Florida, September 1991.

Francis, W., and the editors of Washington Consumers' Checkbook, *Checkbook's Guide to 1982 Health Insurance Plans for Federal Employees*, Washington, D.C., 1982.

Freund, D. and Hurley, R., "Managed Care in Medicaid: Selected Issues in Program Origins, Design, and Research," *Annual Review of Public Health*, Volume 8 , pp. 137–163, 1987.

Fuchs, V.R. and Hahn, J.S., "How Does Canada Do It? A Comparison of Expenditures for Physicians Services in the United States and Canada," *New England Journal of Medicine*, Volume 323, pp. 884–890, 1990.

Fuchs, V.R., "Health Care and the United States Economic System,"*Milbank Mem. Fund Q/Health & Soc.*, Volume 1, Number 2 (Part I), p. 211, 1972.

Gabel, J., et al., "Trends in Managed Care," *Health Insurance Association of America*, Washington, D.C., 1989.

Ginsburg, R.B., "Altering the Tax Treatment of Employment-Based Plans," *Milbank Mem. Fund Q./Health & Soc.*, Volume 59, Number 2, p. 32, 1981.

Globerman, S., "Waiting Your Turn: Hospital Waiting Lists in Canada," Fraser Institute, Vancouver, May 1990.

Goodwin, C., "U.S. Miracle Workers Take Pay Cuts to Help Canadians," The Kirchner-Waterloo (Ontario) *Record*, February 15, 1990.

Greenspan, N. and Vogel, R., "Taxation and its Effect upon Public and Private Health Insurance and Medical Demand," *Health Care Financing Review*, Volume 1, pp. 39–45, Spring 1980.

Hadley, J. and Langwell, K., "Managed Care in the United States: Promises, Evidence to Date, and Future Directions," *Health Policy*, 1991.

Hahn, R.A., Teutsch, S.M., Rothenberg R.B., Marks, J.S., "Excess Deaths from Nine Chronic Diseases in the United States, 1986," *Journal of the American Medical Association*, Volume 264, pp. 2654–2659, Nov. 28, 1990.

Harvard Medical Practice Study, *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Compensation in New*

York, President and Fellows of Harvard College, Cambridge, Mass, 1990.

Health Care Financing Administration, Medicare Hospital Mortality Information: 1986, 1987, 1988. U.S. Department of Health and Human Services, Baltimore, MD. 1989.

Health Care Financing Administration, *Hospital Data And Rehospitalization by Geographic Area for Aged Medicare Beneficiaries,* Volume 1–3, Health Care Financing Special Report, HCFA Publication Numbers 03300, 03301, 03303, U.S Government Printing Office, Washington, D.C., June 1990.

Health Care Financing Administration, *Report to Congress: Paying Physicians — Choices for Medicare,* Office of Research and Demonstrations, sent by the Secretary of Health and Human Services to the U.S. Congress, October 1989.

Health Insurance Association of America, *Canadian Health Care: The Implication of Public Health Insurance,* prepared by E. Neuschler, HIAA Research Bulletin, June 1990.

Hellinger, F., "Selection Bias in Health Maintenance Organizations: Analysis of Recent Evidence," *Health Care Financing Review,* Volume 9, Number 2, pp. 55–63, Winter 198

Hillman, B.J., Joseph, C.A., Mabry, M.R., Sunshine, J.H., Kennedy, S.D., Noether, M., "Frequency and Costs of Diagnostic Imaging in Office Practice: A Comparison of Self-Referring and Radiologist-Referring Physicians," *New England Journal of Medicine,* Volume 323, Number 23, pp. 1604–1608, December 6, 1990.

Holmer, M., "Tax Policy And The Demand For Health Insurance" *Journal of Health Economics,* pp. 202–221, December 1984.

Hsiao, W., "Public Versus Private Administration of Health Insurance: A Study in Relative Economic Efficiency," *Inquiry,* Volume 15, p. 379, 1978.

Hurley, R. and Freund, D., "A Typology of Medicaid Managed Care," *Medical Care,* Volume 26, pp. 764–773, 1988.

Iglehart J.K., "Canada's Health Care System," *New England Journal of Medicine,* Volume 315, Number 3, p. 202–208, July 17, 1986.

Kim, H., "Canada Tabs Washington Hospital," *Modern Health Care,* March 26, 1990.

Langwell, K., "Structure and Performance of Health Maintenance Organizations: A Review," *Health Care Financing Review,* Volume 12, Number 1, pp. 71–79, Fall 1990.

Levit, K., Lazenby, H., Letsch, S., and Cowan, C., "National Health Spending, 1989," *Health Affairs,* Volume 10, Number 1, Spring 1989.

Luft, H., *Health Maintenance Organizations: Dimensions of Performance,* A Wiley InterScience Publication: John Wiley and Sons, New York, New York, 1981.

Luft, H.S., "HMOs and Medical Costs: The Rhetoric and the Evidence," *New England Journal of Medicine,* Volume 298, p. 1336, 1978.

Luft, H.S., "Health Maintenance Organizations: Competition, Costs Containment, and National Health Insurance," in *National Health Insurance: What Now, What Later, What Never?* M.V. Pauly (ed.) American Enterprise Institute, Washington, D.C., 1980.

Luft, H.S., "How Do Health Maintenance Organizations Achieve Their Savings?" *New England Journal of Medicine,* pp. 1336–1343, June 15, 1978.

Manning, W.G., Newhouse, J.P., Duan, N., Keeler, E.B., Leibowitz, A., and Marquis, M.S., "Health Insurance and the Demand for Medical Care," *The American Economics Review,* Volume 3, pp. 251–276, June 1987.

Manning, W.G., Leibowitz, A., Goldberg, F.A., Rogers, W.G., Newhouse, J.D., "A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Service," *New England Journal of Medicine,* Volume 310, pp. 1506–1510, 1984.

Marquis, M.S., *Consumers' Knowledge About Their Health Insurance Coverage,* RAND Corporation, Santa Monica, California, July 1981.

McCaffree, K.M., Boscha, M.V., Drucker, W.L., et al., "Comparative Costs of Services," in *The Seattle Prepaid Health Care Project:*

Comparison of Health Services Delivery, NTIS No. PB–267 491, Springfield, Virginia, 1976.

Monheit, A., and P. Short, "Mandatory Health Coverage," *Health Affairs,* Volume 8, Number 1, Winter 1989.

Moser J.E. and Musacchio, R.A., "The Costs of Medical Professional Liability in the 1980's," *Medical Practice and Management,* pp. 6–9, Summer 1991.

Needleman, J., Sheils, J. and Lewin, L., *The Health Care Financing System and the Uninsured,* Lewin and Associates, Washington, D.C., under contract to the Health Care Financing Administration, April 1990.

Newhouse, J., et al., "Are Fee for Service Costs Increasing Faster than HMO Costs?," *Medical Care,* Volume 23, Number 8, pp. 960–966, August 1985.

Newhouse, J., Manning, W., Norris, C., et al., "Some Interim Results from a Controlled Trial of Cost-Sharing in Health Insurance," *New England Journal of Medicine,* Volume 305, pp. 1501–1507, 1981.

Newhouse, J.P., *The Economics of Medical Care: A Policy Perspective,* Addison-Wesley Publishing Co., Reading, Mass., 1978.

Newhouse, J.P., Anderson, G., Roos, L.L., "Hospital Spending in the United States and Canada: A Comparison," *Health Affairs,* pp. 6–16, Winter, 1988.

Organization for Economic and Cooperative Development (OECD), *Health Systems: Facts and Trends,* Paris, forthcoming 1992.

Pauly, M.V., "Taxation, Health Insurance, and Market Failure in the Medical Economy," *The Journal of Economic Literature,* Volume 2, pp. 629–675, June 1986.

Pauly, M.V., "The Economics of Moral Hazard: Comment," *American Economic Review,* Volume 58, Number 3, p. 531, 1968.

Pauly, M.V., "Future Research Needs: Competition in the Financing and Delivery of Health Services," presented to NCHSR Briefing, Washington, D.C., March 4, 1982.

Pauly, M.V., "Is Medical Care Different?" in *Competition in the Health Care Sector: Past, Present and Future,* W. Greenberg (ed.) Federal Trade Commission, Bureau of Economics, Washington, D.C., May 1978.

Pauly, M.V. "Overinsurance: The Conceptual Issues," in *National Health Insurance: What Now, What Later, What Never?* M.V. Pauly (ed.), American Enterprise Institute, Washington, D.C., 1980.

Pauly, M.V., "The Role of the Private Sector in National Health Insurance," Health Insurance Institute, Washington, D.C., 1979.

Pauly, M.V., "What is Unnecessary Surgery?" *Milbank Mem. Fund Q.* Volume 57, Number 1, p. 95, 1979.

Prospective Payment Assessment Commission, *Report and Recommendations to the Congress,* Washington, D.C., March 1990.

Reynolds, R.A., Rizzo, J.A., Gonzalez, M.L., "The Costs of Medical Professional Liability," *Journal of the American Medical Association,* Volume 257, Number 20, pp. 2776–2781, 1987.

Rice, T., "Containing Health Care Costs in the United States," Public Policy Institute, American Association of Retired Persons, Washington, D.C., May 1991.

Robinson, J.C., "HMO Market Penetration and Hospital Cost Inflation in California, *Journal of the American Medical Association,* Volume 266, Number 19, pp. 2719–2723, 1991.

Roemer, M.I., "Group Practice: A Medical Care Spectrum," in *Health Insurance Plans: Studies in Organization Diversity,* M.I. Roehmer, D.M. DuBois, and S.W. Rich (eds.), School of Public Health, University of California, Los Angeles, 1972.

Roemer, M.I. and Shonick, W., "HMO Performance: The Recent Evidence," *Milbank Mem. Fund Q.,* Volume 51, p. 271, 1973.

Roos, L.L., Fisher, E.S., Sharp, S.M., et al., "Postsurgical Mortality in Manitoba and New England," *Journal of the American Medical Association,* Volume 263, Number 18, pp. 2453–2458, May 9, 1990.

Roos, L.L., Wennberg, J.E., Malenka, D.J., et al., "Mortality and Reoperation after Prostatic Hyperplasia," *New England Journal of Medicine,* Volume 320, pp. 1120–1124, 1989.

Rossiter, L., et al., "Patient Satisfaction among Elderly Enrollees and Disenrollees in Medicare Health Maintenance Organizations," *Journal of the American Medical Association*, Volume 262, pp. 57–63, 1989.

Rublee, D., "Medical Technology in Canada, Germany, and the United States," *Health Affairs*, Volume 8, Number 3, p. 181, Fall 1989.

Scheffler, R.M., Gibbs, J.O., and Gurnick D.A., "The Impact of Medicare's Prospective Payment System and Private Sector Initiatives: Blue Cross Experience, 1980–1986," Blue Cross and Blue Shield Association and the Research Program in Health Economics, University of California, Berkeley, CA, 1988.

Schieber, G. and Poullier, J., "International Health Spending: Issues and Trends," *Health Affairs*, Volume 10, Number 1, pp. 106–116, Spring 1991.

Schieber, G., Poullier J., and Greenwald L.M., "Health Care Systems in Twenty-Four Countries," *Health Affairs*, pp. 23–38, Fall 1991.

Schwartz, L., "The Medical Costs of America's Social Ills," *Wall Street Journal*, June 24, 1991.

Sherlock, K., "Detroit Offers Short Wait For Health Surgery," *The Edmonton Journal*, January 6, 1990.

Sonnefeld, S.T., Waldo, D.R., Lemieux J.A., and McKusik, D.R., "Projections of National Health Expenditures Through the Year 2000," *Health Care Financing Review*, Volume 7, Number 3, pp. 1–27.

Advisory Council on Social Security, *Commitment to Change: Foundations for Reform*, Social Security Commission Survey, Washington, D.C., December 1991.

Taylor, C.R., *Universal Health Care in Maryland: A Consumer Choice Approach*, December 1991.

Taylor, A.M. and Wilensky, G.B., "The Effect of Tax Policies on Expenditures for Private Health Insurance," in *Market Reforms in Health Care*, pp. 163–184, Jack Meyer (ed.), American Enterprise Institute, Washington, D.C., 1983.

U.S. Department of Health and Human Services, *Health, United States, 1990*, National Center for Health Statistics, Public Health Service, Hyattsville, Maryland, March 1991.

U.S. Congress, *Health Care Resource Book*, Committee on Ways and Means, House of Representatives, U.S. Government Printing Office, Washington, D.C., April 16, 1990.

U.S. Congress, Congressional Budget Office, *Selected Options for Expanding Health Insurance Coverage*, U.S. Government Printing Office, Washington, D.C., July 1991.

U.S. General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, GAO/HRD–91–90, Washington, D.C., June 1991.

U.S. General Accounting Office, *Medicare: Effect of Durable Medical Equipment Fee Schedules on Six Suppliers' Profits*, GAO/HR-92-22, Washington, D.C., November 1991.

Waldo, D.R., Sonnefeld, S.T., Lemieux, J.A., McKusik, D.R., "Health Spending Through 2030: Three Scenarios," *Health Affairs*, Volume 10, Number 4, pp. 231–242, 1991.

Washington State Hospital Association, *Weekly Report*, Volume 15, Number 8, February 23, 1989.

Welch, W.P., "HMO Market Share and its Effect on Local Medicare Costs," Urban Institute, Washington, D.C., report to the Health Care Financing Administration, under Cooperative Agreement #17-C-99223/3-01, December 1990.

Wennberg, J., Barnes, B., and Zubkoff, M., "Professional Uncertainty and the Problem of Supplier-Induced Demand," *Social Science and Medicine*, Volume 16, pp. 811–824, 1982.

Wilensky, G.R., "Government and the Financing of Health Care," *American Economic Review*, Volume 72, Number 2, p. 202, 1982.

Wilensky, G.R. and Rossiter, L.F., "Coordinated Care and Public Programs," *Health Affairs*, pp. 63–77, Winter 1991.

Wolinsky, F.D., "The Performance of Health Maintenance Organizations: An Analytic Review," *Milbank Mem Fund Q/Health & Society*, Volume 58, p. 537, 1980.

Woolhandler, S. and Himmelstein, D.U., "The Deteriorating Administrative Efficiency of the U.S. Health Care System," *New England Journal of Medicine,* Volume 324, pp. 1243–1258, 1991.

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